
Mid-term evaluation of the Maternal and Newborn Health Thematic Fund

Phase III 2018-2022



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MID-TERM EVALUATION OF THE MATERNAL AND NEWBORN HEALTH THEMATIC FUND PHASE III, 2018-2022

Evaluation Office

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ABBREVIATIONS AND ACRONYMS

| | |
|----------|---|
| ADHO | Assistant district health officer |
| AFD | Agence Française de Développement |
| ANC | Antenatal care |
| ASRO | Arab States regional office |
| BEmONC | Basic emergency obstetrics and newborn care |
| BEPC | Brevet d'Etudes Du Premier Cycle - Undergraduate Studies Certificate (Benin) |
| BMS | Bangladesh Midwifery Society |
| CAC | Comprehensive abortion care |
| CAFA | Community Animator Friendly Association |
| CAMES | African and Malagasy Confederation of Higher Education) |
| CEmONC | Comprehensive emergency obstetrics and newborn care |
| CHAZ | Church Health Association of Zambia |
| CO | Country office |
| COVID-19 | 2019 novel coronavirus/Corona virus disease/SARS-CoV-2 |
| CQI | Continuous quality improvement |
| CP | Country programme |
| CSO | Civil society organisation |
| D&A | Disrespect and abuse |
| DGFP | Directorate General of Family Planning (Bangladesh) |
| DGHS | Directorate General of Health Services (Bangladesh) |
| DHIS | District health information system |
| DHT | District health team (Uganda) |
| DHO | District health officer |
| ECLB | Essential care for labour and birth |
| EmONC | Emergency obstetric and newborn care |
| ENAP | Every Newborn Action Plan |
| EPMM | Ending Preventable Maternal Mortality initiative |
| FASFAF | Federation of Midwives Association of Francophone Africa |
| FCDO | Foreign, Commonwealth and Development Office (UK) |
| FGM | Female genital mutilation |
| FIGO | International Federation of Gynaecologists and Obstetricians |
| FMoH | Federal Ministry of Health (Sudan) |
| GBV | Gender-based violence |
| GFF | Global Financing Facility |
| GIS | Geographic Information System |
| H6 | A group comprising six United Nations health agencies (WHO, UNAIDS UNFPA, UNICEF, UN Women, World Bank) |
| HBB | Helping Babies Breathe |
| HC | Health centre |
| HCW | Health centre worker (Uganda) |
| HDU | High dependency unit |
| HIV | Human immunodeficiency virus |
| HMIS | Health management information system |
| HMS | Helping Mothers Survive |

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|----------|---|
| HQ | Headquarters |
| HRH | Human resources for health |
| HSS | Health systems strengthening |
| HUMC | Health unit management committee |
| ICM | International Confederation of Midwives |
| ICU | Intensive care unit |
| IDM | International day of the midwife |
| iNGO | International non-governmental organisation |
| IP | Implementing partner |
| IPC | Infection prevention and control |
| IsDB | Islamic Development Bank |
| LARC | Long-acting reversable contraception |
| LMD | License Master Doctorate (Benin) |
| LSTM | Liverpool School of Tropical Medicine |
| MAZ | Midwives Association of Zambia |
| MCH | Maternal and child health |
| MDG | Millennium Development Goal |
| MDR | Maternal death review |
| MDSR | Maternal death surveillance and response |
| MHTF | Maternal and Newborn Health Thematic Fund |
| MISP | Minimum initial service package for SRH in emergencies |
| MMR | Maternal mortality ratio |
| MNH | Maternal and newborn health |
| MoES | Ministry of Education and Sports (Uganda) |
| MoH | Ministry of Health |
| MoH&FW | Ministry of Health and Family Welfare (Bangladesh) |
| MoU | Memorandum of understanding |
| MPDSR | Maternal and perinatal death surveillance and response |
| MR | Mortality rate |
| MSU | Marie Stopes Uganda |
| MVA | Manual vacuum aspiration |
| NEAPACOH | Network of African Parliamentary Committees on Health |
| NGO | Non-governmental organisation |
| NMDRC | National maternal death review committee |
| NRH | National referral hospital (Uganda) |
| Ob/Gyn | Obstetrics and gynaecology |
| OF | Obstetric fistula |
| OGSB | The Obstetrical and Gynaecological Society of Bangladesh |
| PAC | Post-abortion care |
| PHC | Primary health care |
| PHO | Provincial health officer |
| PMTCT | Preventing mother to child transmission of HIV |
| PNC | Postnatal care |
| PNDS | Le plan national de développement sanitaire – National Health Development Plan (Togo) |
| PPE | Personal protective equipment |
| PPH | Post-partum haemorrhage |

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|-----------------|---|
| QED | Quality Equity Dignity |
| QI | Quality improvement |
| RBF | Results based financing |
| RH | Reproductive health |
| RMC | Respectful maternity care |
| RMNCAH | Reproductive, maternal, newborn, child, and adolescent health |
| RMNCAH&N | Reproductive, maternal, newborn, child, adolescent health and nutrition |
| RO | Regional office |
| RRH | Regional referral hospital (Uganda) |
| SDG | Sustainable Development Goal |
| SGBV | Sexual and gender-based violence |
| Sida | Swedish International Development Cooperation Agency |
| SMAG | Safe motherhood action group (Zambia) |
| SMDRC | State maternal death review committee (Sudan) |
| SMoH | State Ministry of Health (Sudan) |
| SNMP | Strengthening the national midwifery programme (Bangladesh) |
| SoWMy | The State of the World's Midwifery |
| SRH | Sexual and reproductive health |
| SRHR | Sexual and reproductive health and rights |
| SRMNAH | Sexual, reproductive, maternal, newborn adolescent health |
| SRMNCAH | Sexual, reproductive, maternal, newborn, child and adolescent health |
| SRMNH | Sexual, reproductive, maternal and newborn health care |
| STI | Sexually transmitted infections |
| SuMA | Sudan Midwifery Association |
| The Global Fund | The Global Fund to fight AIDS, Tuberculosis and Malaria |
| TWG | Technical working group |
| UDHS | Uganda demographic health survey |
| UHC | Universal health coverage |
| UN | United Nations |
| UNICEF | United nations Children's Fund |
| UNIGE | University of Geneva |
| UNMC | Uganda Nurse and Midwives Council |
| USAID | United States Agency for International Development |
| VHT | Village health team (Uganda) |
| VIA | Visual inspection of the cervix with acetic acid |
| WAHO | West African Health Organization |
| WB | World Bank |
| WCARO | West and Central Africa regional office |
| WHO | World Health Organization |
| WWC | Woodrow Wilson International Centre |
| ZAGO | Zambia Association of Gynaecologists and Obstetricians |

ANNEX 1: Evaluation matrix

| Area of Investigation 1: Midwifery | |
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| Evaluation Question 1: To what extent has the MHTF contributed to ensuring the education, training, and deployment of an adequately skilled/competent, motivated and sustainable midwifery workforce? | |
| Sub-questions: | |
| <p>a) How has the Maternal and Newborn Health Thematic Fund (MHTF) contributed to strengthening the enabling policy and regulatory environment for midwives, including reinforced regulation of midwives (output 2) and increased use of gender-sensitive policies, strategies and plans to recruit, deploy and retain midwives (output 4), and policies to regulate the work environment for midwives, including supportive supervision, mentorship professional development, and assurance of a conducive and safe work environment (outcome 5)</p> <p>b) To what extent has the MHTF contributed to the capacities of a skilled and competent midwifery workforce, educated according to global standards and that meet national needs (output 1)</p> <p>c) To what extent has MHTF contributed to strengthening the capacities of midwifery associations to help raise the profile of midwifery, represent the professional needs of midwives, and provide professional support and continuing education? (Output 3)</p> | |
| Evaluation criteria | <i>Relevance, effectiveness, efficiency, sustainability</i> |
| Rationale | Midwives play a central role as caregivers for women and their newborns throughout the continuum of care from pre-pregnancy to the post-partum period; and are positioned to provide comprehensive sexual and reproductive health information and services, including family planning, antenatal care, safe normal deliveries, basic emergency obstetric and newborn care (EmONC), essential newborn care, prevention of sexually transmitted infections (STIs) and transmission of HIV from mother to child, prevention of fistula and other morbidities, and prevention of female genital mutilation/cutting. To fulfil these roles, there is a need to strengthen midwifery education and training, enable and support midwife autonomy including ensuring midwives can work across their scope of practice, strengthen workforce policies and create a work environment that empowers midwives. These aims are central to achieving other outcomes of the MHTF, i.e., through expanded linkages with fistula prevention and elimination of female genital mutilation/cutting, in collecting, analysing and using data as part of MPDSR; and the deployment of midwives in EmONC facilities. |
| Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries | |
| Indicators: | |
| <ul style="list-style-type: none"> ● National policies, strategies and plans to govern midwifery practice and workforce capacity development, including supporting midwife autonomy, gender-sensitive policies, strategies and plans to recruit, deploy, and retain midwives, midwifery included in Human Resource policies ● Strengthened regulatory bodies that govern midwifery practice, certification, accreditation, monitoring and accountability and that regulate quality of care, client safety and satisfaction | |

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| <ul style="list-style-type: none"> ● Strengthened policies, guidelines and standards related to supportive supervision, mentorship, professional development, and a safe and conducive work environment ● Views and experiences of partners and health authorities at global and national level regarding effectiveness of UNFPA leadership to advocate for evidence-based policies, strategies, plans and regulations ● Alignment of UNFPA policy inputs with MHTF core principles (equity, quality of care, accountability plus human rights and gender equality) | |
| Observations | Sources of evidence |
| Global | |
| <p>Global strategy/guidance on midwifery:</p> <ul style="list-style-type: none"> ● The 2021 State of the World’s Midwifery sets forth the case to increase commitment to and investment in the midwifery workforce as an essential component for meeting the Sustainable Development Goals (SDGs) related to sexual, reproductive, maternal, newborn, and adolescent health. Previous reports were issued in 2011 and 2014. The report is a collaboration between UNFPA, WHO and International Confederation of Midwives (ICM) and highlights a current shortage of 1.1 million workers dedicated to sexual and reproductive health–maternal and newborn health (SRH-MNH), of which the largest shortage is of midwives (900,000). ● The report sets out the key areas of investment needed, including health workforce planning and regulation; high quality education and training; midwife-led improvements in service delivery; and midwifery leadership and governance. ● The report also calls for a gender transformative work environment. Because midwives are more likely to be women, they experience gendered disparities in pay, career paths and decision-making authority. Only half of countries included in the report have midwife leaders within their national Ministry of Health (MoH). ● UNFPA has produced four regional State of the World’s Midwifery (SoWMy) reports in the Pacific sub-region (2019), East and Southern Africa region (2017), Arab States region (2015), and Latin America/Caribbean region (2014). | <p>UNFPA, ICM and WHO. The State of the World’s Midwifery. New York: UNFPA; 2021</p> |
| <ul style="list-style-type: none"> ● A 2020 modelling study using the Lives Saved Tool (LiST) found that a substantial increase in coverage of midwife-delivered interventions could avert 41 per cent of maternal deaths, 39 per cent of neonatal deaths and 26 per cent of stillbirths, accounting for 2.2 million deaths averted per year by 2035. To achieve these results, investments are needed to ensure midwives have the skills and competencies in line with recommendations from ICM. ● The LiST models the effect of changes in health intervention coverage on mortality using the best available estimates of health status and population size. The modelled interventions were based on midwife competencies as defined by ICM. Five scenarios of coverage were modelled: no scale-up, modest scale-up, substantial scale-up, universal coverage and attrition. ● Even a modest scale-up of midwife-delivered interventions would result in 22 per cent fewer maternal deaths. Scaling up universal coverage could result in 67 per cent fewer maternal deaths, with the reductions proportionally the greatest in low HDI countries. | <p>Nove, A, Friberg, IK, de Bernis, L, McConville, F, Moran, AC, Majjemba, M, et al. Potential impact of midwives in preventing and reducing maternal mortality. The Lancet Global Health. Vol 9, No. 1 E24-E32, 01 January 2021. Accessed from: https://doi.org/10.1016/S2214-109X(20)30397-1</p> |
| <ul style="list-style-type: none"> ● In September 2016, a global consultation of UNFPA midwifery technical advisors and programme managers from 30 MHTF countries and global midwifery partners was organized in Geneva to draw upon the lessons learned from 8 years of implementation of the MHTF and to discuss the successes, good practices, lessons learned and continuing challenges of the | <p>UNFPA. Global Midwifery Strategy 2018-2030. New York: UNFPA; 2018.</p> |

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midwifery programme to better address existing SRMNAH needs and gaps in countries. The **existing Midwifery Strategy that currently focuses on the 3 pillars of strengthening Education, Regulation and Association was also reviewed** in light of achievements and lessons learned and participants discussed ways to better align it with the Health SDG target of eliminating maternal and newborn mortality by 2030 and **achieving universal health coverage and UN SG’s Strategy on Women’s and Children’s Health. Quality midwifery care can help increase women’s decision-making capacities and their ability to take care of themselves and their families, which changes their role in the community and society they live in.** (p.1)

- The strategy includes a **vision statement**, “Supporting provision of quality of maternal and newborn care to save lives and strengthen women’s capabilities to take care of themselves and their lives” and a theory of change that includes the following elements to contribute to the result that “all women have access to quality midwifery services and care” (impact):
 - Education: **Midwives are competent and trained** in accordance with international standards and can progress in their careers
 - Regulation: Midwives are **enabled to be accountable and autonomous** in their practice providing service users with quality sexual reproductive newborn adolescent health (SRMNAH) care
 - Association: Countries have a strong, **fully functional, and well-organized midwifery association**
 - Midwifery workforce: **National recruitment, deployment, and retention capacity** increased, and facilities better staffed
 - Enabling environment: **A supportive legal and policy framework** that enables midwives to provide respectful quality SRMNAH health care
 - Recognition of midwifery: Midwifery care is **recognized as integral part of sexual and reproductive health and rights (SRHR)** (p.6)

- The purpose of this guidance is to assist country offices (COs), programme managers, partner agencies, and MoH midwifery managers to **develop, scale-up or strengthen midwifery programmes at national level** and mainstream midwifery in national human resources for health (HRH) agenda.
- The guidance complements and references a wealth of work on midwifery strengthening already undertaken by a number of partner organizations, including the **State of the World’s Midwifery Report 2011, WHO Midwifery Strengthening Toolkit, Jhpiego/MCHIP Pre-Service Education Toolkit for Midwives and UNFPA/WHO/Intel/Jhpiego e-learning modules on essential maternal and newborn life- saving skills.** It however, does not prescribe a uniform policy, but rather offers ideas, recommendations and suggestions from experiences, lessons learnt and best practices that countries can adapt to suit their context. Each of the following technical sections provides guidance along with examples of good practices:
 - Ch. 1 Engaging Stakeholders and Building Partnerships
 - Ch. 2 Programme Development and Strengthening: Planning and Needs Assessment, Midwifery Services Framework
 - Ch. 3 Strengthening Midwifery: Education, Regulation and Association
 - Ch. 4 Advocacy and Communication
 - Ch. 5 Fundraising and Resource Mobilization.
 - Ch. 6 Monitoring and Evaluation (p.9)

UNFPA and ICM. Comprehensive Midwifery Programme Guidance. 2015

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| <ul style="list-style-type: none"> ● In a peer-reviewed editorial, UNFPA posited that midwives are essential for sustaining attention and investment in the midst of the COVID-19 pandemic response, given the tragic consequences from lack of access to EmONC, SRH and gender-based violence (GBV) services. As a result, they should be protected from pressures to provide general care to COVID-19 patients. They should be “protected from infection, by access to sufficient personal protective equipment (PPE) and have a safe work environment dedicated for providing sexual, reproductive, maternal and newborn health care (SRMNH), and be free from violence, stigma and discrimination.” | <p>Bar-Zeev, S, Breen-Kamkong, C, ten Hoop-Bender, P, Sahbani, S, Abdullah, M. UNFPA supporting midwives at the heart of the COVID-19 response, <i>Women and Birth</i>, Volume 34, Issue 1, 2021, Pages 4-6, accessed from: https://doi.org/10.1016/j.wombi.2020.08.005</p> |
| <ul style="list-style-type: none"> ● UNFPA has provided strong, focused leadership in midwifery, with clear messaging. The strategy developed guides the work they are doing; enables them to include a focus on newborn care. MHTF has supported UNFPA to be more visible; this visibility has helped partners to take them seriously, to put sexual and reproductive health and rights (SRHR) on the agenda. “They have really brought investment and attention to midwives and are the only organization, with ICM, that has focused on midwifery. When ICM talks about midwives, it is seen as having a vested interest; however, the UNFPA platform gives more heft and weight as UNFPA is focused more broadly on SRHR. As a UN agency, UNFPA has clout and their work on midwifery sends a powerful message. Even though it is very hierarchical and layered, they have managed to go forward with MHTF funding. | <p>Interview, Implementing partner, September 2021</p> |
| <p>Global partnerships in support of midwifery advocacy and programming</p> <ul style="list-style-type: none"> ● The ICM 2020 workplan (USD 215,000) supports the ICM-UNFPA partnership to deliver a broad range of initiatives to contribute to the professionalization of midwifery globally and strengthening ICM national member associations locally and regionally. Activities included: <ul style="list-style-type: none"> ○ Advocacy toolkits for Year of the Midwife and International Days of Midwives ○ Dissemination of UNFPA and other guidelines, including but not limited to, ICM/UNFPA Call to action on COVID-19, Advocacy and other toolkits for member associations, Respectful care guidelines and online course ○ SoWMy data collection, analysis, preparation for dissemination in 2021. | <p>UNFPA, ICM Workplan Amendment #1. 2020</p> |
| <ul style="list-style-type: none"> ● Liverpool School of Tropical Medicine (LSTM) will contribute to delivering core activities related to mentorship and capacity building, for the UNFPA ACCESS project and the MHTF. The ACCESS project, managed by the SRH branch - UNFPA HQ, aims to strengthen the access, utilization, and quality of comprehensive abortion care (CAC) in Africa, particularly medical abortion. Clinical mentorship training is one intervention that will be implemented in this project to enhance the knowledge, attitudes and skills of personnel selected for clinical mentoring to prepare them to effectively guide providers to competently perform abortion-related care and EmONC. ● UNFPA is partnering with LSTM to strengthen capacities of the health workforce, especially midwives, in clinical and management skills to deliver high-quality and integrated SRHR services, including in humanitarian settings. 2020 workplan activities (USD 59,185) include: <ul style="list-style-type: none"> ○ Development of a mentorship training workshop package and onsite mentorship programme | <p>UNFPA, Liverpool School of Tropical Medicine (UK) Workplan. 2020.</p> |

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| <ul style="list-style-type: none"> ○ Development of a CAC refresher training module ○ On-line facilitation of mentorship training and CAC refresher training, including a technical update of existing e-learning modules for EmONC and the development of a new e-module on CAC. | |
| <ul style="list-style-type: none"> ● UNFPA has been partnering with Woodrow Wilson International Centre for Scholars' (WWC) Advancing Dialogue on Maternal Health for over a decade. Each year WWC collaborates with UNFPA to hold four meetings, generally two public events and two private roundtables. In 2020 two thematic foci were discussed, the Year of the Nurse Midwife and the devastating effects of unsafe abortion around the world (USD 92,000) ● The workplan is supported under the MHTF programme objective to strengthen national capacity to implement comprehensive midwifery programmes. | UNFPA, 2020 Workplan with WWC. 2020 |
| <ul style="list-style-type: none"> ● WWC is a non-partisan, non-advocacy "think tank", which tries to bring together a diverse set of people and views to inform policy and education. The Maternal Health initiative of the WWC has partnered with UNFPA for over a decade to conduct forums to discuss best practices and emerging issues in maternal health. Prior to COVID-19, the convenings would be held in DC, four per year. Convening would either be large public events or smaller, roundtable events. Usually, the events include some social media presence beforehand, followed by a published article and a podcast after the event to continue the process. Now all events are virtual; an unexpected side benefit is that more people can attend. ● Working with UNFPA brings a lot of added value by virtue of its long history and renowned contributions to SRH and women and girls. Working with UNFPA is central to the mission of the maternal health initiative at WWC. Even though they fund the work, the relationship is beyond financial as they are aligned to the WWC mission and bring strong technical expertise. ● Midwifery is featured in many of the forums; in 2020 the thematic focus was on indigenous midwives. UNFPA also collaborated with WWC on the launch of the State of the World's Midwifery (SoWMy) report in 2021. | Interview, Implementing partner, September 2021 |
| <ul style="list-style-type: none"> ● Key issues for midwifery in the global context include gender inequality for women and midwives; midwives have no autonomy as they operate, in many cases, in patriarchal contexts. The medicalization of care is also an issue and effects how and to whom resources are allocated. Most SRH is done by midwives, so it is them we should think about. They are marginalized and conflated with the rest of the workforce. "Midwifery as women's work by women – double whammy" ● There are many opportunities to use evidence and data to support strategies and decision-making. [However, the SDG measures do not include qualitative issues such as quality of life, disrespect in service delivery]. ● Important to tackle gender inequality; it requires good leadership and a voice at the table. We need to think long term and not consider midwifery too narrowly. A lesson learned from the pandemic is to focus on primary and community-based care. When maternity services are centralized, women do not get care because of fear. But they will get services from a community midwife with good connections to secondary and tertiary care facilities. | Interview, Implementing partner, September 2021. |
| <ul style="list-style-type: none"> ● The four technical areas of MHTF are not sufficiently linked; a competent midwife, e.g., a competent midwife means you do not have fistula. However, in many countries, there were missed opportunities to link the HQ-defined priorities at country level. For example, although clearly connected to each other, the fistula and midwifery programmes in Bangladesh were not | Interview, Development partner (private foundation), August 2021 |

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| <p>connected. In Lao, maternal and perinatal death surveillance and response (MPDSR) only included doctors, not midwives. The obvious links at the health system level were not made.</p> <ul style="list-style-type: none"> ● Working in siloes in countries meant that the approach was a bit wasteful of resources and technical expertise. The best use of funds should be on prevention, with a strong midwifery cadre in a strong referral system. ● Midwifery could be the driver for advancements. The SoWMy and Lancet publications are great advances and position UNFPA as a leader on midwifery. CO representative attitudes are pivotal. Midwifery is at the table where representatives know the value and importance; many representatives are not aware of the importance of midwifery. | |
| <ul style="list-style-type: none"> ● MHTF has huge potential; midwifery is key and there is the opportunity to link midwifery to the broader SRHR agenda. To achieve this, the profession needs to be set up, delivered, expanded, before that integration can happen. ● Partnering with ICM and other global partners has been strategic for MHTF efforts. Midwifery is a success story for MHTF. There is a need for more communication between midwifery and EmONC teams and services in MHTF countries; need to be more strategically linked. | Interview, Development partner (bilateral), July 2021 |
| <ul style="list-style-type: none"> ● The real strength of MHTF is to make the case for investments. This is not a short-term process; takes a long time. UNFPA has been working on midwifery for 10 years and “building all the time.” ● Bangladesh is a prominent example. Initially supported by UNFPA through MHTF investment, movement in midwifery was strengthened with support from Canada, UK, Sweden. Now MHTF not the main leader; should withdraw as others take over. In Cambodia, the situation and funding improved with MHTF funding and MHTF withdrew. ● Overall, it makes sense to invest in midwifery. There is a lot of evidence for doing so. UNFPA doesn’t understand to value of midwives; WHO dilutes midwifery. | Interview, Development partner (bilateral), July 2021 |
| <ul style="list-style-type: none"> ● Strengthening midwifery is essential to maternal health. “No one talks about maternal health rights – proper maternal care is a human right. Strengthening midwifery care is vital and all hands-on deck there” (at UNFPA). ● A lot of money goes to ICM to support professionalization component of ICM. This is important to strengthen advocacy voice at country level, but not sure whether this is through the midwifery association or through leadership courses in country. Is ICM a pass-through of funds? Is it good value for money? | Interview, UN agency, July 2021 |
| <ul style="list-style-type: none"> ● UNFPA has filled an important role in the space of maternal health within the UN. Prior to UNFPA engagement, “maternal health was a black hole.” ● The UNFPA partnership with ICM is “brilliant; ICM is the world leader in midwifery and that is the best approach. However, ICM is not on par with International Federation of Gynaecologists and Obstetricians (FIGO). From a gender perspective, midwives need more parity with doctors. Midwifery as a cadre is slow to get going.” ● With more resources, UNFPA could address the “how” of the normative guidance from WHO that everyone has contributed to. The constraints in different settings require efforts to translate normative guidance to the specific contexts. | Interview, UN agency, September 2021 |
| <ul style="list-style-type: none"> ● Midwifery is one of the most important of the four pillars in MHTF. Where you have strong midwifery programmes, there are better outcomes for women. | Interview, UNFPA MHTF staff, New York, February 2021 |

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| <ul style="list-style-type: none"> • UNFPA has worked with WHO to elevate the status of midwives through policy work with governments. • Midwifery is at the heart of MHTF; without support for midwifery, the other areas would not be as effective. • At global level, MHTF produces the SoWMy report and the Lancet report. | Interview, UNFPA MHTF staff, New York, May 2021 |
| <ul style="list-style-type: none"> • Midwifery was a separate, stand-alone programme, but was incorporated into MHTF as part of an effort to take a more integrated approach. “You cannot just do midwifery and think that you are going to improve maternal health – you need to focus on the three other components as well, although fistula is an outlier, but it is an effect of what happens in the other three areas.” A health system strengthening approach is most effective. | Interview, UNFPA staff, New York, March 2021 |
| <ul style="list-style-type: none"> • The new midwifery strategy is guiding us through three new pillars (workforce policy, enabling environment, integration around midwifery) in addition to the three traditional pillars (education, regulation, and association). • ICM is an important partnership as it represents 140 midwifery associations from 10 countries. At first, the partnership focused on a lot of advocacy and building the evidence base. The decision to produce the State of Midwifery Report created an “uproar” as it was the first report that had data on midwifery work and spoke to the value of midwives. The report created such a buzz that three regional offices (ROs) did their own reports for use in programme planning and advocacy, with funding from MHTF. Over time, the midwifery work has gone from “quick fix” to something more comprehensive. ICM capacity has been building through this partnership. It has had a technical impact through the development of global standards and benchmarks. Prior to this work, there were no standards on education, regulation and association. | Interview, MHTF staff, New York, February 2021 |
| Regional | |
| <ul style="list-style-type: none"> • No observations | |
| Benin | |
| <ul style="list-style-type: none"> • UNFPA accompagne la réglementation de l’enseignement des sage-femmes depuis 10 ans • Réforme LMD (Licence Master Doctorat) en 2010/2011 – par le CAMES (Conférence africaine et malgache de l’enseignement supérieur): Formation axée sur compétences (avant, les sages-femmes avaient seulement le brevet) ; relèvement du niveau des sages-femmes au bac. Changement du contenu des curricula (licence en soins obstétricaux). Ces réformes ont eu des répercussions sur le traitement salarial, les écoles sont passées sous la tutelle des universités. • Les curricula cadrent avec le modèle régional de l’OOAS (Organisation Ouest Africaine de la Santé), suivant les recommandations du CAMES, établi à partir des compétences définies par l’OMS pour la pratique d’infirmier et de sage-femme. • UNFPA a accompagné les structures mises en place pour faire face aux défis liés à ces réformes. | Entretien, Ministère de la Santé, Cadre supérieur, technique, Benin, Mai 2021 |
| <p>Défis liés au nouveau cadre réglementaire de la pratique des sage-femmes : Tensions entre différents groupes de sage-femme</p> <ul style="list-style-type: none"> • L’un des principaux défis est que nous avons aujourd’hui plusieurs catégories de sage-femmes. Il y a les anciennes qui sont entrées à l’école avec le BEPC. Il y a celles qui sont le produit de la réforme LMD (avec niveau Licence) et les autres qui vont faire la formation dans les écoles du Burkina, Niger et Guinée. Entre les anciennes et les licenciées, il y a un conflit latent alors que le BEPC avant équivalait au BAC et plus. | Entretien, National Ministère de la Santé Manager, Juin 2021, Benin |

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| <p>Aller plus loin et élaborer un référentiel de métier</p> <ul style="list-style-type: none"> ● L'évaluation de la qualité des études initiales de sage-femme au Bénin nous permet de dégager des recommandations stratégiques et opérationnelles, y compris clarifier, formaliser et valoriser l'identité professionnelle et le champ de pratique de sage-femme au Bénin et élaborer un référentiel de métier selon une approche multidisciplinaire, participative et consensuelle pour convenir des caractéristiques de la profession de sage-femme au Bénin, intégrer la déclinaison de l'utilisation des services de SSR par type de professionnel de santé dans les enquêtes nationales et y intégrer la sage-femme, convenir d'un plan de progression professionnelle (spécialités liées à la pratique de sage-femme) et académique des sage-femmes (pédagogie, recherche, psychologie, sociologie, anthropologie, ...) | <p>Evaluation de la qualité des études de sages-femmes au Benin Rapport d'évaluation 2020</p> |
| <p>Sudan</p> | |
| <p>Process to develop midwifery norms and standards</p> <ul style="list-style-type: none"> ● Workshop participants included policy makers, representatives of the FMOH officers from different departments, UN Agencies, International NGOs (JICA and Carter Centre), representatives of civil society and the midwifery association. The workshop was highly participatory, with a series of discussions, group work and presentations, which presented platforms for discussing sensitive issues and addressing tensions between professional groups, individuals and different departments and institutions. ● The main activities included the official opening by the Undersecretary for Health, Dr Ismeldin Mohamed A. Abdalla and welcome by the UNFPA Country Representative, Dr Lina Moussa. ● On day one, the concept of gap analysis, an overview of ICM, a definition of a midwife and roles and responsibilities of a midwife in Sudan generated very useful discussions. This illustrated that although there is an urgent need for the development of professional midwives, the government and all its partners are eager to develop and strengthen midwifery competency and midwifery services. ● The gap analysis identified critical structural drivers of health that harm women and girls (for example, female genital cutting) anticipating the role of gender-sensitive policies and strategies needed across all elements of midwifery education and professionalisation. ● Days 2 to 4 were dedicated to sharing the ICM Global Standards, competencies, gap analysis tools and the results. All participants contributed to the development of each pillar of Education, Regulation and Association development. | <p>UNFPA, International Confederation of Midwives (ICM), MoH, Sudan Midwifery Gap Analysis, 2018, UNFPA, Khartoum, Sudan</p> |
| <p>UNFPA support to midwifery reforms</p> <ul style="list-style-type: none"> ● UNFPA supported the midwifery reform starting from 2016 through direct coordination with the MCH directorate rather than with the Academy of Health Sciences directly. That support continues. Although they make a limited direct contribution, UNFPA supports the Academy of Health Sciences to conduct monitoring and evaluation field missions and channels other support via the FMOH (MCH directorate). ● Celebrating 100 years for midwifery programme, UNFPA is now supporting the FMOH to develop an advocacy plan to increase community awareness on the role of midwives. The plan includes dissemination of messages through media, successful stories and other communications. | <p>Interview, National Policy and Teaching Partner, Khartoum, 3 June 2021</p> |

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| <p>Midwifery: a UNFPA priority</p> <ul style="list-style-type: none"> UNFPA identifies midwifery as one of its major areas of focus and says it is very engaged, “...Taking the lead jointly with the government to support the midwifery programme”. UNFPA is contributing to midwifery on several levels including policy, guidelines, regulatory processes, awareness and communications, and training. The need is very high, and even together UNFPA and the FMOH cannot cover all the needs. | <p>Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021</p> |
| <ul style="list-style-type: none"> UNFPA is considered the main partner supporting the national midwifery programme. UNFPA supports the midwifery reform, which aims to undertake a situation analysis and gap analysis and based on that, to develop a strategic framework to improve midwifery performance. The national midwifery programme is identified as a strategic opportunity to accelerate the abandonment of harmful practices and increase gender equity for women and girls. Midwives will need high quality training and ongoing supervision and management to strengthen progress. | <p>Interview with National Health Sector Manager, FMOH, Khartoum, 1 June 2021</p> |
| <p>Progress on midwifery norms, standards and guidelines</p> <ul style="list-style-type: none"> Sudan Midwifery Gap Analysis is completed, and it will be followed by the development of a midwifery strategy, a process that is taking place in August 2018. Early in 2018, UNFPA supported MoH to conduct a second study tour to Morocco to comprehensively study the midwifery education programme implementation through field visits to midwifery schools/colleges. The visit also aimed at exploring opportunities for collaboration between Morocco and Sudan ministries of health. The CO completed the Sudan Midwifery Gap Analysis, and a dissemination of the findings was done in a national workshop that was facilitated by consultants from the ICM in August 2018. The workshop was attended by all relevant stakeholders including Federal and states MoH, academic institutions, the midwifery association, the national medical specialization board, nursing association, obstetrics and gynaecology association among other partners. A four-year midwifery work-force improvement strategic plan was drafted in the same workshop. Later, in November 2018, dissemination and endorsement of the strategic plans was done. | <p>UNFPA, MHTF 2018 Midyear Progress Report - Sudan, 2018, UNFPA, Khartoum, Sudan, p.3</p> |
| <p>The role of midwives in the Sudan health system</p> <ul style="list-style-type: none"> High school degrees were reported as the minimum requirement to be trained as a midwife, auxiliary midwife, and nurse-midwife in all countries offering academic training in these professions, which require three to four years to complete. As followed in all educational models, the training of physicians takes around six to seven years, and specializations in obstetrics and gynaecology require an additional four to five years. An obvious lack of complementarity arises in the division of tasks between general physicians, obstetrician/gynaecologists (Ob/Gyns), and the midwifery cadre. Physicians and specialists bear the majority of responsibilities, with minimal exclusive roles given to midwifery personnel. An exception to this is Sudan, where midwives are given more roles than in other countries in this assessment. In general, the emphasis is more on clinical tasks than on other aspects of care, such as cross-cultural communication and promotion of shared responsibility with women, families, and the community in all these countries. Tasks relating to labour and birth care are shared between general physicians, OB/GYNs, and midwives. | <p>Kabakian-Khasholian T, and Ali A, UNFPA Assessment of Sexual and Reproductive Health Integration in Selected Arab States, The Middle East and North Africa Health Policy Forum (MENA HPF) and UNFPA ASRO, Cairo, December 2017, p.32</p> |

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| <p>UNFPA supports national policy and no longer trains community midwives</p> <ul style="list-style-type: none"> • Usually, UNFPA supports a wide range of RH programmes • State Ministry of Health (SMoH) conducts activities, which are agreed upon after a needs assessments and discussion between the two parties on ways to address identified problems and challenges. Then a memorandum of understanding (MoU) is signed. • However, sometimes urgent needs outside of the MoU appear and to which UNFPA usually responds if they are able. Unfortunately, this year there were a number of serious needs for basic midwifery training in 42 areas where deliveries are done by non-trained community midwives and UNFPA refused to support because the policy has changed in that basic training is no longer offered to community midwives due to the imminent launch of the new diploma. | <p>Interview, SMoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021</p> |
| Uganda | |
| <p>UNFPA-MoH collaboration in midwifery</p> <ul style="list-style-type: none"> • UNFPA has provided critical support to midwifery in Uganda, i.e., improving awareness (through midwifery days and associated events), improving policies for midwives (i.e. the scope of practice), and training and mentorship in infectious prevention control (IPC) during the COVID-19 pandemic. For the latter activity, UNFPA provided support to the MoH at national level, and then the MoH implements mentorship at the regional and district level. This activity was related to COVID-19 – IPC for midwives and conducted in the UNFPA-supported districts, i.e., Gulu, Arua, Naibi, Zumbu, Yumbe, Napak, Nakipiripirit, Moroto, and Kanungu. • UNFPA has also provided funds for a consultant to support the MoH in the process to develop the national midwives’ policy (scope of practice for midwives), currently under development). | <p>Interview, MoH national staff, Kampala, Uganda, May 2021</p> |
| <p>Midwife Scope of Practice policy</p> <ul style="list-style-type: none"> • UNFPA supports the NMNC (under the MoH) to revise the midwives’ and nurses’ scope of practice. (The UNMC regulates the Nursing and Midwifery professionals in the country.) • The revised version will enable midwives to perform assisted deliveries (vacuum extraction, etc.) to increase availability and quality of BEmONC services. The revision started in 2018 or 2019; it is not yet completed, but it is in the final stages and was sent to the Solicitor General to approve the legal aspects of the document. Feedback was given and now the next stage is to have stakeholders agree on the new aspects and scope of practice. • The main area of UNFPA support in the policy and regulatory arena is the support for the Scope of Practice policy. MHTF kick-started the process and enabled UNFPA to develop the scope of practice as well as support the processes which are quite long and complicated. FCDO-UK support under the RISE (family planning) programme complemented MHTF funding. With cuts of UK funding, the Council is using its funding to ensure that the Scope of Practice policy process is completed. “The MoH helped mobilize additional support from Global. We have not yet entirely filled the funding gap for UNFPA.” | <p>Interview, MoH national staff, Kampala, Uganda, May 2021</p> <p>Interview, UNFPA staff. Kampala, Uganda, May 2021</p> |
| <p>Strengthening planning through scale up of GIS</p> <ul style="list-style-type: none"> • UNFPA continues to support UNMC Council through the MoH to scale up the GIS, a system that tracks the presence of midwives and informs the MoH and MoES on the midwifery workforce requirements at each level. The system also tracks | <p>UNFPA Uganda, 2019 Annual MHTF Report, 2019, p.4</p> |

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| <p>deployment of midwives to informs the HR needs/gaps for midwives. With support from the MHTF, UNMC sensitized leaders in seven districts of Moroto, Kotido, Napak, Nabilatuk, Kiryandongo, Yumbe, Kampala to understand and utilize the system. In the same districts a total of 563 Midwives were trained on how to use the system. Ten districts have been covered with support from the MHTF and an additional 10 districts have been covered with support from Sida, making a cumulative total of 20 districts where GIS has been introduced in Uganda. Cumulatively, a total of 1775 midwives countrywide have been enrolled onto the GIS.</p> | |
| <ul style="list-style-type: none"> • The GIS project was started in 2018-2019 fiscal year. Prior to that, compliance with license renewals was 60 per cent; now, it is 73 per cent. The MoH TWG approved the GIS as the “de-facto system” for reporting nationally. • Prior to GIS, it took about three years for license renewal as compared to annually in other countries. “It was a big black box – we did not know how many were practicing, how many retired or died.” In places where the GIS is not yet rolled out, nurses and midwives still have to come for manual registration. “UNFPA has a passion for midwives in the hard-to-reach areas and led us to have this GIS solution....which has improved registration, licensing, and meeting districts’ needs.” • The GIS is a mapping system which helps register and license midwives and nurses. The GIS “communicates” or interfaces with the” integrated human resources for health” (iHRH) system (the national iHRH database) created with support from IntraHealth and USAID). The MoH TWG is responsible for approving protocols for reporting. Thirteen regional registration centres were established in the regional referral hospitals. “We compare what we have in our GIS system and ask the DHO to give us data. We work with the Senior Principal Nursing Officer in the RRH, and they work actively with each Assistant DHO (for maternal health) to track and register the nurses and midwives in their districts.” • The National Health Services Commission and the District Health Services Commission are responsible for recruitment. When districts hire, the national level does not get the information in real time. The aim of the GIS is to access and view data across districts using the online platform. UNFPA provided funding through the MoH to pilot the GIS in three districts and then added 24 more districts, with more to add this year. It supported validation exercises whereby the district was supported to ask all practicing midwives and nurses to present their degree certificates for validation and entering into the GIS. • An example of the GIS impact on quality is in the Kitodo district where the number of illegal practitioners was high. “The implementation of GIS resulted in the reduction of illegal practices and now it is one of the best performing districts.” | <p>Interview, NGO partner. Kampala, Uganda, May 2021</p> |
| Zambia | |
| Support for midwifery protocols | |
| <ul style="list-style-type: none"> • UNFPA supported the development of Nursing and Midwifery Protocols, whose implementation is expected to facilitate improved quality of care across the country. | UNFPA Zambia. 2018 Annual Report. 2019 |
| <ul style="list-style-type: none"> • The regulatory body responsible for setting midwifery standards was supported by MHTF to review the Midwifery Regulatory Framework, Midwifery protocols and the incorporation of ICM standards and competencies into the curricula. This enhances the Council’s capacity to monitor quality of care. | UNFPA Zambia. MHTF Achievements 2018-2020. Undated. |
| <ul style="list-style-type: none"> • UNFPA work with midwives has been quite robust, including working on midwifery regulation through the Midwifery Council, with the support of the global midwifery global programme. The MHTF was the first time to have such a program with a | Interview, UNFPA Zambia staff. August 2021. |

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| <p>specific staff person assigned to steer the work with midwives. UNFPA received good recognition through that programme at country level with the programmes on midwifery education, strengthening the midwifery curriculum, and building the skills of educators in EmONC and other areas.</p> | |
| <p>Identifying human resources gaps in skilled birth attendance</p> <ul style="list-style-type: none"> UNFPA supported the development and dissemination of the National Human Resources for Health Strategic Plan (2018-2024) which details key approaches for addressing human resources for health challenges in the country, including the need for skilled birth attendants and the critical role of community health workers towards improving the availability of services. | <p>UNFPA Zambia. 2018 Annual Report. 2019</p> |
| <p>Respectful Maternity Care</p> <ul style="list-style-type: none"> A key strategy to achieve Vision 2030 in Zambia is to address high maternal and newborn morbidity and mortality through an increase in the proportion of births attended by skilled birth attendants (SBAs). To do so will require addressing the deep-rooted gender inequalities that manifest in early marriages, adolescent pregnancy, and inadequate access to SRH services. “Institutionalizing RMC in family planning, antenatal care (ANC), postpartum or postnatal care (PNC) and essential care for labour and birth (ECLB) will dignify maternity care and encourage women to delivery in health facilities.” (p. 4) Disrespect and abuse (D&A) include seven different behaviours manifested by health providers: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities. Factors that contribute to D&A include individual and community-level factors, normalization of D&A, lack of legal and ethical foundations to address D&A, lack of leadership, lack of standards and accountability, and provider prejudice due to lack of training and resources. (p.4) “Studies conducted in Zambia revealed several facts that emphasize D&A as a pressing problem in Lusaka, Kitwe and Ndola facilities: <ul style="list-style-type: none"> D&A faced by women during labor poses a barrier to facility delivery Beliefs related to health and future welfare of the baby and recovery and well-being of women in the post-partum period leading to restrictions on women’s diet and movement respectively Many midwives confessing the mistreatment of women at health facilities during the labor period Operational context not being conducive to allowing maternal autonomy and empowerment as advocated during midwifery training Overwhelming condemnation of traditional beliefs and practices among the midwives because of the perceived negative impact they have on delivery outcomes About 22% of women’s right to confidentiality and privacy were not adhered to, 42% women reported that there were no drapes or covering to protect their privacy and 19% indicated that there were no curtains or other visual barrier to protect woman during examinations Providing non-dignified care including 63% of the women and/or companion not being allowed to observe cultural practices and 20% of the women being talked to in an impolite manner | <p>MoH, Zambia. Promoting Respectful Maternity Care in Zambia: Facilitator’s Facility-based Training Manual. 2020</p> |

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| <ul style="list-style-type: none"> ○ 13 % of the women were discriminated based on specific attributes. This stems from women indicating that 19% of the service provider’s showed D&A based on any specific attributes and 6% of the service provider did not speak to women in a language at a level that they could understand ○ Onn average, 18% of the women had experienced physical abuse by a service provider during child birth⁸ ○ Prominent issues that led to ill-treatment included 43% of the women not provided comfort/pain-relief and 26% of the women were touched in a cultural inappropriate way ○ One in 10 (10%) of the women indicating that the service provider used physical force or abrasive behaviour claiming that food or fluid in labor were not medically necessary and separated woman from her baby.” (p.5) <ul style="list-style-type: none"> ● The training manual includes activities and materials designed to promote increased support, advocacy and provision of quality, women-centred maternity care. It is designed for use by programme managers, supervisors, trainers, technical advisors and others who organize or facilitate trainings in SRH, EmONC, Helping Mothers Survive Bleeding After Birth Complete (HMSBABC), Healing Babies Breathe (HBB), Essential Care for Labour and Birth (ECLB) and pre-eclampsia and eclampsia. | |
| <ul style="list-style-type: none"> ● MoH has put maternal health as a priority agenda in terms of policy, implementation, and other issues. Specifically, for the Ministry, I know we have nurses who are not midwives who are attending to maternal health services, particularly in rural areas. But it makes a very big difference if most of these were attended to by midwives who have been trained to provide the service and have the knowledge, skill and attitudes required. | <p>Interview, MoH service provider. August 2021.</p> |
| <p>Bangladesh</p> | |
| <ul style="list-style-type: none"> ● UNFPA was the technical agency which guided government to design the midwifery programme ‘which took off like fire’. UNFPA provides technical support, develops required documentation (e.g. job descriptions, standard operating procedures (SOPs), strategies, policy guidelines and standards), carries out advocacy and follows up on various initiatives regarding policies/procedures - UNFPA appoints dedicated staff with high standing to follow up on policy issues and bring about changes in policies and practices Strengthening education programme: UNFPA was responsible for leading development of curriculum, lesson plans, faculty orientation. Given the dearth of faculty members UNFPA worked with Auckland University for faculty development, has organized on-site/online education of potential students to obtain masters in SRHR from Dalarna University of Sweden. Other investments in faculty development include introducing teaching pedagogy for labs, classrooms and facilities, inclusion of midwives in GBV. UNFPA helped to improve more effective use of educational resources including computer labs, demonstration labs by facilitating better access of students to these labs. ● Strengthening profile of midwives and empowering them in facilities through mentors. Encouraging faculties to model one faculty to one patient. Introducing midwifery-led care in one Upazila Health Complex. ● Strengthening capacity of midwifery association. UNFPA played lead role in establishment and strengthening of Bangladesh Midwifery Society (BMS). BMS has been able to develop passion for the profession among its members. It has become a strong networking platform, and is being used for holding virtual meetings, continuous professional education, accessing contact information of other midwives, coordinating voluntary activities, e.g. during COVID-19 and coordinating activities for | <p>International Midwifery Specialist, UNFPA, Dhaka, Bangladesh, June 2021</p> |

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| protecting the interest of midwives, e.g. holding protests against a decision (wrongly) perceived to be against the interest of midwives. BMS has been twinned with Royal College of Midwives for its development and functioning. However more work needs to be done for self-sustaining BMS and strengthening continuous professional education. | |
| <ul style="list-style-type: none"> It was UNFPA advocacy which led to the development of midwifery as a professional cadre, although total ownership of the programme has been given to the government. UNFPA advocacy has also resulted in mainstreaming midwifery in government's national programme. Thus, the Directorate General of Nursing has been changed to Directorate General of Nursing and Midwifery (DGNM), a separate stream of people to work on midwifery has been in put in place at DGNM with a Deputy Director, Assistant Director, Officers and support staff. To develop faculty, UNFPA has put through 150 midwives through a Masters in Sexual Reproductive Health and Rights (SRHR) from Dalarna University, Sweden. 120 midwives have already completed the course and 30 will complete by 2022. The midwifery course is 40 per cent theory and 60 per cent practical and students have to undertake 40 normal vaginal delivery for certification. The curriculum is competency based and approved by International Confederation of Midwives (ICM) who were brought in by UNFPA and helped to revise the curriculum. The Bachelor of Science degree (BSc) and Master of Science degree (MSc) curriculum is also being developed with technical and financial assistance from UNFPA. | Midwifery Officer, Nursing and Midwifery, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> UNFPA is the acknowledged leader of development partners, multilateral agencies and Government of Bangladesh (GoB) for technical development of midwifery in Bangladesh. It has played this role most effectively, as a result of which within a short time, midwifery which was an absolutely new profession in 2016 is now established in the country and expanding fast. | Adviser, Foreign, Commonwealth and Development Office (FCDO), Dhaka, Bangladesh, June 2021 |
| Togo | |
| <ul style="list-style-type: none"> Grâce aux Fonds français MUSKOKA, l'UNFPA, l'OMS et l'UNICEF apportent un appui à la mise en œuvre du plan stratégique intégré de la santé de la mère, du nouveau-né, de l'Enfant et de l'Adolescent (SMNEA), en particulier dans le domaine des SONU et la SDMN, deux interventions sur lesquelles le fonds MHTF de l'UNFPA ont joué un rôle catalytique faisant du Bureau UNFPA le lead au Togo sur la question des SONU et sa mise en œuvre un modèle dans la sous-région malgré les résultats encore insatisfaisants. Le fonds MHTF apporte un appui non négligeable dans la promotion de la pratique sage-femme. Les progrès en cours portent entre autres, sur une intégration des SONU dans le plan de santé maternelle et néonatale avec un cadre programmatique au point : le réseau SONU, qui a été défini et revisité en 2018, un monitoring régulier qui analyse la situation et fournit des données sur la disponibilité et la qualité des soins, et qui fait avec la SDMN, l'éventail régulier des dysfonctionnements en cours dans le système de soins, causes des décès maternel ; un effort d'intégration du paquet de la santé, la refonte des curricula de formation des sages-femmes, pour une adaptation aux standard ICM et OMS, le renforcement des compétences des monitrices pour l'encadrement des étudiantes, sans oublier les efforts en cours pour rehausser leur qualification à la base (formation au niveau Master) ; la définition d'un nouveau cadre de la pratique sages-femmes au Togo en cours ; le diagnostic quoi que partiel, disponible sur la pratique sages-femmes. | UNFPA, MHTF Request Proposal 2019-2022, 2019 |
| <ul style="list-style-type: none"> Activité 15 : Plaidoyer pour l'adoption par le Ministère de la Santé du Cadre réglementaire de la pratique sages-femmes <ul style="list-style-type: none"> Resultat attendu : Le cadre réglementaire est adopté par le Gouvernement togolais Status : Non Réalisé | UNFPA, MHTF Request Proposal 2019-2022, 2019 |

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| Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries | |
| <ul style="list-style-type: none"> ○ Commentaire : Le règlement intérieur de l'Ordre national des sages-femmes ont été élaborés en 2015 et soumis par l'Association de Sages-femmes au Ministère de la Santé et accompagné d'un plaidoyer constant et soutenu pour instituer l'Ordre de Sage-femme, mais ceci n'a pas encore abouti. | |
| <ul style="list-style-type: none"> ● Toutes les actions que les nations-Unies font au Togo, c'est amener le gouvernement à augmenter son budget. Dans le PNDS, la santé maternelle figure en bonne place pour pouvoir bénéficier de financement conséquent. | UNICEF staff, UNICEF, June 2021, Togo |
| <ul style="list-style-type: none"> ● UNFPA entretient un dialogue permanent avec le ministère de la santé pour le recrutement des sages-femmes Finance la reconnaissance des sages-femmes méritantes. | UNFPA staff, UNFPA, June 2021, Togo |
| <ul style="list-style-type: none"> ● Insuffisances : Manque du personnel Sage-Femme en nombre suffisant, faibles plateaux techniques, faute d'appropriation de l'intervention par le niveau opération pour un meilleur suivi des prestataires. | UNFPA staff, UNFPA, June 2021, Togo |
| <ul style="list-style-type: none"> ● UNFPA a appuyé l'élaboration des textes réglementaires ont été élaborés et validés en 2015 qui attendent leur adoption afin d'une institutionnalisation de l'ordre des sages-femmes du Togo. Les actions de plaidoyer continuent dans ce sens. | UNFPA staff, UNFPA, June 2021, Togo |
| <ul style="list-style-type: none"> ● La refonte des curricula de formation des sages-femmes, pour une adaptation aux standard ICM et OMS, le renforcement des compétences des monitrices pour l'encadrement des étudiantes, sans oublier les efforts en cours pour rehausser leur qualification à la base (formation au niveau Master) ; la définition d'un nouveau cadre de la pratique sage-femme au Togo en cours ; le diagnostic quoi que partiel, disponible sur la pratique sage-femme. | UNFPA, MHTF Request Proposal 2019-2022, 2019 |
| Online survey | |
| Question 4: Main areas of UNFPA contribution | |
| <ul style="list-style-type: none"> ● Midwifery was the top named "main contribution of UNFPA MHTF to MNH/public health results in your country" by 28.15 per cent of respondents, followed by support to end fistula (11.76 per cent), EmONC (11.34 per cent) and MPDSR (10.92 per cent). | |
| Question 6: Extent of agreement with UNFPA contributions/results in midwifery | |
| <ul style="list-style-type: none"> ● Survey respondents overwhelmingly agreed/strongly agreed (88.68 per cent) with the statement that UNFPA inputs regarding norms, standards and policies have resulted in the strengthening of regulatory and policy environment to govern midwifery practice and workforce capacity development. ● Although responses were overall positive to this question, the category that got the least agreement was the statement that there has been a sustained increase of national investments in midwifery education and expansion of the midwifery workforce: 19.27 per cent of respondents neither agreed/disagreed and 5.21 per cent disagreed. | |
| Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education | |
| Indicators: | |
| <ul style="list-style-type: none"> ● Number of midwifery schools (public and private) supported by the MHTF that are accredited by the government based on global standards set by WHO and ICM ● MHTF support for midwifery education programmes aligns with national needs. | |

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education

- Examples of MHTF support to strengthen capacity¹ of midwifery schools to provide quality pre-service training, including necessary teaching materials, commodities and equipment and incentives to motivate teachers and students
- Examples of MHTF support for standardized, competency-based education programmes that bridge competency development trainings (i.e., in-service training, continuing education) for midwives and tutors
- National midwife education programmes are aligned with global standards for competency-based training and accreditation
- Views and experiences of partners, health authorities, and midwifery educators regarding the relevance, technical quality, and effectiveness of UNFPA support for midwifery education programmes.
- National programme plans include efforts to institutionalize² (sustain) standardized, competency-based education of midwives
- Alignment of UNFPA policy inputs with MHTF core principles (equity, quality of care, accountability plus human rights and gender equality)
- Number of innovations developed to enhance midwifery education and continuous training.

Observations

Sources of evidence

Global

- MHTF supports **capacity-building of country midwifery advisors**. Not all countries have a midwifery advisor, and even when they exist, **they are given other roles** or sometimes they are responsible for the whole MHTF portfolio. Working on curricula take a lot of time, not realistic given staffing levels. Funding is miniscule for the tasks assigned.
- Major challenges exist, i.e., **most midwives graduate without clinical skills**. The benchmark is for each midwife to participate in 40 deliveries and manage 20 independently before being qualified.
- Health systems are entrenched – some **health systems have five categories of midwives**. To bridge from certificate to diploma programmes is difficult.
- Every country is so **different in terms of their educational approach**, how midwives transition from training into the workforce, and how they move forward professionally. **MHTF is currently working on a standardized model curriculum** to address the lack of standardization and quality and in response to requests from midwives for a framework they can implement. It will also support the development of internal (UNFPA) capacity. One consistent challenge is that midwives graduate without the competencies they need to provide care, EmONC, continuity of care and to adapt and acclimate to the workforce. Under development is a Midwife entry into practice programme, i.e., internship, so that new practitioners have the opportunity to rotate and to help with staff retention.

Interview, Global MHTF staff, February 2021

- MHTF is working with the **Maternity Foundation on the Safe Delivery App**, an innovation to support midwifery tutors to **conduct training, supportive supervision and mentorship in the field**. It includes nine modules on key obstetrical

Interview, Global MHTF staff, February 2021

¹ The COM-B model of behaviour change (Mayne 2016) will be used to assess provider capacity based on three necessary conditions: 1) capability (necessary knowledge, skills, and attitudes to deliver quality care), 2) opportunity (having the necessary infrastructure, equipment, supplies and tools to deliver quality care), and 3) motivation (internal cognitive and emotional processes related to willingness and perceived personal benefit of providing good quality of services).

² Institutionalization means that the Ministry of Education and/or Health has adopted UNFPA-supported curriculum changes as their own standard for midwifery education.

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emergencies, eclampsia, post-abortion care (PAC), infection, etc. This is an initiative of the Maternity Foundation, with UNFPA providing technical guidance on content. UNFPA also supported a mobile learning system (small projector, solar charger, installed e-modules). It was first launched in Tanzania and Ethiopia, then Rwanda. Rwanda wanted a nationwide launch, but it was implemented in one district in 2018.

- **UNFPA partners with the Maternity Foundation, a Danish NGO** working to ensure safer childbirth through innovative and mobile health solutions and programme to improve maternal and newborn health (MNH) in low- and middle-income countries. The Maternity Foundation is behind the **Safe Delivery App, a mobile training tool for skilled birth attendants** being rolled out in Africa and Asia. The partnership goes back five years and started off with UNFPA providing a strategic open door for the foundation with stakeholders in countries (not financial). At global level, the Maternity Foundation relied on UNFPA to validate technical content and provide inputs for modules. Now UNFPA and the Maternity Foundation collaborate in six countries (in Africa, Southeast Asia plus Haiti) with contractual agreements and at global level (also to translate materials for Arabic and LAC regions).
- The **main purpose of the tool is for midwives to have handy information on evidence-based practices for EmONC** as they are working. It is an in-service job aid and provides advice, for example, on how to administer a drug. It is also used more broadly as a mentoring tool. There is a whole set of activities for learning consisting of 400 questions over three different levels of activities. Once you go through the whole programme you qualify for a safe delivery champion certificate and midwives can get continuing professional development points. Over the last year, Maternity Foundation started to work in the arena of pre-service education. The app has been used by students to better understand hands-on procedures. It is also used by educators to make teaching more learner-based rather than didactic, i.e., “blended learning.” It can also be used as a self-directed tool and for online training. The app is available in three languages, and it is aligned to international standards and protocols.
- Future directions include **addressing the needs of young cadres of midwives**, for example in the Arabic region; review and validation of the safe abortion module; advocacy for disseminating data and learning about how digital tools are used. A small toolbox is being developed to support the measurement of skills retention and knowledge.
- At global level, UNFPA has been very collaborative. They have paved the way to enter dialogues at regional and country level. There are on-going dialogues in Nepal, skilled-based training in PNG, Maldives, Cambodia and Myanmar. Bangladesh is no active at present, but is engaged; there is a Bangla version of the app. After a year of dialogue in Uganda, the MoH decided not to go ahead with piloting the app. Apart from UNFPA, the Maternity Foundation has on-going engagements in 15 countries, and the app is used in 40 countries. It has gone beyond piloting.
- “I give UNFPA a thumbs up, compared to other UN agencies, as there is an openness to new ways of working, i.e., digital solutions.”

Interview, Implementing Partner, October, 2021

Regional

- No observations

Bangladesh

| Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education | |
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| <ul style="list-style-type: none"> ● The Bangladesh Midwifery Mentorship Programme supported by the UNFPA utilizes a structured mentorship model and trained mentors to bolster the capacities of midwives and enhance evidence-based maternal and newborn care. The model helps create an enabling environment for midwives. The results highlight how well-structured mentorship can greatly improve the obstetric and newborn competencies of midwives and therefore strengthen the quality of maternal and newborn care services within a country. This mentoring model has recently been adapted for midwifery faculty at educational sites as well to strengthen the implementation of the curriculum, enhance skills training and improve critical thinking. | <p>Bangladesh Midwifery Mentorship Programme, unknown year, p. 8</p> |
| <ul style="list-style-type: none"> ● UNFPA was the technical agency which guided government to design the midwifery programme ‘which took off like fire’. ... UNFPA was responsible for leading development of curriculum, lesson plans, faculty orientation. Given the dearth of faculty members UNFPA worked with Auckland University for faculty development, has organized on-site/online education of potential students to obtain masters in SRHR from Dalarna University of Sweden. Other investments in faculty development include introducing teaching pedagogy for labs, classrooms and facilities, inclusion of midwives in GBV. UNFPA helped to improve more effective use of educational resources including computer labs, demonstration labs by facilitating better access of students to these labs. Strengthening profile of midwives and empowering them in facilities through mentors. Encouraging faculties to model one faculty to one patient. Introducing midwifery-led care in one Upazila Health Complex. Strengthening capacity of midwifery association. | <p>International Midwifery Specialist, UNFPA, Dhaka, Bangladesh, June 2021</p> |
| <ul style="list-style-type: none"> ● MHTF’s objectives/focus: Work on developing a midwifery programme started after the Prime Minister’s declaration in 2010. Since the country had no midwives at that time, it was decided that nurses with Diploma in Nursing and Midwifery will be given additional training for six months and allowed to work as ‘Certified Midwives’, while preparation would be taken for introducing a Diploma midwifery education programme. Under this scheme 1,600 Certified Midwives were created of who 1,200 were later posted in various government facilities to work as midwives and 400 were posted as Public Health Nurses under the Civil Surgeon at District level to supervise the work of Midwives/Certified Midwives; some underwent the Dalarna University SRHR Masters course and became faculty for the Diploma course, and some went back to nursing. MHTF funds were used for this purpose. The MHTF funds during this interim period were also used to prepare for the launching of the Diploma programme and midwifery cadre. | <p>Midwifery Officer, Nursing and Midwifery, Dhaka, Bangladesh, June 2021</p> |
| <ul style="list-style-type: none"> ● It was UNFPA advocacy which led to the development of midwifery as a professional cadre, although total ownership of the programme has been given to the government. UNFPA advocacy has also resulted in mainstreaming midwifery in government’s national programme. | <p>Midwifery Officer, Nursing and Midwifery, Dhaka, Bangladesh, June 2021</p> |
| <ul style="list-style-type: none"> ● UNFPA has played a key leadership role in promoting and supporting all aspects of midwifery including policy, regulation, education, deployment, establishment of BMS (Bangladesh Midwifery Society). It is the “sole technical agency for Midwifery” as recognized by the development partners promoting Midwifery in Bangladesh (Global Affairs Canada, FCDO, WHO, WB, Sida). | <p>Adviser, FCDO, Dhaka, Bangladesh, June 2021</p> |
| Benin | |

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| <p>Contribution du MHTF sur la mise aux normes de la formation</p> <ul style="list-style-type: none"> • Une évaluation de la qualité des études de sage-femmes a été conduite en 2019/20 et a pointé le manque de référence à l'ICM [International Confederation of Midwives], malgré le fait que les responsables des études initiales de sage-femme assurent que les curricula se basent sur les compétences de la sage-femme établies par l'OMS et l'absence de référentiel du métier de sage-femme. De plus, le concept de prise en charge ou soins respectueux n'apparaît dans aucune compétence (compétences terminales, sous compétences) | <p>Evaluation de la qualité des études de sages-femmes au Benin Rapport d'évaluation 2020</p> |
| <ul style="list-style-type: none"> • La dimension intergénérationnelle est à la fois une force et une faiblesse du secteur qui doit bien être prise en considération | <p>UNFPA, Rapport Annuel MHTF 2020</p> |
| <ul style="list-style-type: none"> • Face à ce défi, mise en place du projet « passerelle », destiné à la mise à niveau des sage-femmes diplômées avant l'intégration des études de sage-femmes dans la réforme LMD en 2012, connaît une lenteur administrative qui compromet sa mise en application malgré le soutien financier de l'AFEBE. Cette dernière s'inquiète de l'échéance du projet limitée à 2021. Un répondant chiffre le nombre de sage-femmes concernées par le projet à 3500. | <p>Évaluation de la qualité des études de sages-femmes au Benin, Rapport d'évaluation 2020</p> |
| <p>Le MHTF soutient les deux écoles de sage-femmes qui existent au Benin INMES à Cotonou et IFSIO à Parakou</p> <ul style="list-style-type: none"> • IFSIO : Elèves = 300 ; 12 sage femmes et infirmiers enseignantes (trois sages-femmes) et médecins recrutes (gynéco (six) et psy et chirurgien et cardiologue et vieux physicien ; l'École a six ans <ul style="list-style-type: none"> ○ Les deux écoles œuvrent, avec l'appui des partenaires, dans le sens de l'accréditation régionale de l'OOAS. | <p>Entretien, UNFPA bureau pays, Benin, Mai 2021</p> |
| <p>Appui UNFPA sur la qualité d'enseignement dans les écoles de sage-femme</p> <ul style="list-style-type: none"> • Pratique : UNFPA a doté école de Parakou d'un mannequin ; climatisation pour équiper la salle en 2020 • Consultante (UNFPA) supporte équipe permanente des écoles de Parakou et de Cotonou : Accompagnement formidable ; gestionnaires de l'école la redemandent appui substantiel : <ul style="list-style-type: none"> ○ Séminaire pédagogique sur l'acquisition des compétences cliniques : ○ Renforcement des capacités managériales de l'école supérieure des sage-femmes d'état de l'université de Parakou • Réponse face à l'épidémie de COVID-19 : Gel, savon pour laver mains, gants, serviettes, surblouses ; étudiantes parties en stage ont eu package <ul style="list-style-type: none"> ○ Développement de curricula de formation sur la base de l'évaluation du programme de formation initiale des sage-femmes (prise en charge des femmes enceintes, accouchement sécurisé centré sur les soins respectueux, prise en charge des SONUB, décision/organisation des références, sites de stage clinique) en 2019 | <p>Entretien, UNFPA bureau pays, Benin, Mai 2021</p> |
| <ul style="list-style-type: none"> • UNFPA focalise sur la qualité et cet accompagnement fait du bien pour tout le monde dans le pays. Par exemple au niveau des stages, on a mis en place de mesures pour vérifier les sites choisis, formation des encadreurs de site en amont ; avant, on sélectionnait des hôpitaux basés sur le nombre des accouchements, les stagiaires. | <p>Entretien, Ministère de la Santé, Management, Cotonou, Mai 2021, Bénin</p> |
| <p>Appui sur la qualité de l'encadrement clinique des stages</p> | <p>UNFPA, Atelier de validation des outils du mentorat clinique des</p> |

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| <ul style="list-style-type: none"> ● Etablissement d'un référentiel des critères de sélection des sites de stage clinique des étudiantes sages-femmes: à travers une approche participative, sur la base d'un atelier organisé par Le Ministère de la Santé ● Appui à la supervision de 24 sites de stage clinique (e-Platform) de critères d'identification des sites de stage ● Formations pour sage-femme pour améliorer l'encadrement : Formation des encadreurs des sites de stage clinique sur le contenu des carnets de stage et l'obligation d'utilisation de ces carnets pour le développement des apprentissages et l'acquisition des compétences cliniques par les apprenantes ● Révision des carnets de stage et impression ● Séminaires sur répertoire des stages valides (sites de stage identifiés, grâce au checklist) ● Etablissement d'un outil cartographique des sites de stage élaboré en 2019 | <p>sage-femmes en Afrique de l'Ouest et du Centre, 2019</p> <p>UNFPA Rapport Annuel MHTF 2019</p> |
| <p>Formation continue peu efficiente</p> <ul style="list-style-type: none"> ● Il y a des sage-femmes à qui l'Etat a offert une formation mais qui vont à la retraite peu après. Il faut définir un âge maximal pour aller en formation ; On a fait trop de formation continue. Parfois, pour les formations en cours d'emploi, on a passé 4-5 jours à les former. Vous revenez et les mêmes faux gestes sont d'actualité. ● Pas assez de ressources pour les sages-femmes – en particulier formation continue (pour pallier à rotation du personnel) ● Centres de simulation et de perfectionnement (espace qui permet d'optimiser pratique de sage-femme: essais sur mannequins): avantage est que la sage-femme se sent rassurée et sait qu'elle a un espace pour mise à jour | <p>Groupe de Discussion avec sages-femmes, Juin 2021, Benin</p> <p>Entretien, Ministère de la Santé, Management, Cotonou, Mai 2021, Bénin</p> |
| <p>L'analyse des questions de genre dans les curricula</p> <ul style="list-style-type: none"> ● Le rapport d'évaluation des curricula de sage-femmes explore la question du genre dans la section : "Dispositions législatives et réglementaires définissant la fonction Sage-femme comparées à celles des infirmières et médecins – Prise en compte des aspects équité et genre" ● L'analyse proposée est : Les informations puisées dans les propos recueillis et dans les documents consultés ne permettent pas d'apporter des éléments de réponse précis à cette question. Nous pourrions retenir que, bien que le rôle de la sage-femme soit clairement perçu chez l'ensemble des répondants, il appartient à un parmi d'autres professionnels de santé considérés comme des ressources humaines au même pied d'égalité. La question de genre ne se pose pas puisqu'au Bénin, les sages-femmes sont toutes des femmes. | <p>Evaluation de la qualité des études de sages-femmes au Benin Rapport d'évaluation 2020, p.14</p> |
| Sudan | |
| <p>The transition to the midwifery diploma at State level</p> <ul style="list-style-type: none"> ● UNFPA is our main partner in support of the midwifery schools and for a long time supported the midwifery schools. UNFPA covered the cost of transportation and the subsistence of the student midwives. They also contributed to staff retention costs. In addition, separately from midwifery training, UNFPA provides midwifery kits, supplies and commodities. ● Unfortunately, the school is closed (since 2018) and at national level basic training is no longer supported. ● There are concerns that the plans for a midwifery diploma will not work well here in this state and the diploma will not really produce enough midwives to fill the gap as there is a huge training need in this area. | <p>Interview, SMOH, Ad Damazin, Blue Nile, Sudan, 7 June 2021</p> |

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| <ul style="list-style-type: none"> Usually, women in this state do not receive even basic education and the diploma needs at least secondary school certificates. | |
| UNFPA engagement in midwifery training <ul style="list-style-type: none"> The diploma was arranged with a direct push from UNFPA as quality of pre-service training was poor. There was agreement to shift to a full three-year training programme. ICM had undertaken an assessment in 2017 of training and skills of community midwives. One of the conclusions was a recognition that the training community midwives received was not enough. They needed more and better training delivered through in-service programmes. A discussion was held about interim or bridge phase for building the capacity of existing midwives. Those in service were all reached with an updated service training package. Enrolment may have been less well managed which accounts for the variability [in access] however, there are others providing similar or adjacent training including CAFA, UNICEF, WHO etc. In addition, SMOH and FMOH each have their training programmes and budgets and activities. There was an intention to admit midwives to in-service training based on clear criteria. Although there may have been some coordination, there is a possibility that duplication occurred. The training included infection prevention control and generally aimed to support the FMOH direction of travel on upgrading midwifery capacity. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| UNFPA provides a limited contribution to the Academy of Health Science <ul style="list-style-type: none"> UNFPA supported the Academy to develop an academic diploma for midwives. Curriculum is now ready and approval by the Ministry of Higher Education is underway. Also, UNFPA contributed to the retention of staff at the Midwifery School in Omdurman Maternity Hospital (Aldayat hospital) before it closed, funding the salaries of one lecturer (PhD level) and seven assistants (all midwives) and they received USD 70 and USD 55 respectively (per month). By 2020, this had eroded to a negligible value and was not enough to retain staff. | Interview, National Policy and Teaching Partner, Khartoum, 3 June 2021 |
| Midwifery diploma <ul style="list-style-type: none"> UNFPA fully supported the development of the diploma including the curriculum and design. In the context of the PHC expansion programme, MoH undertook an assessment of skills and delivery of PHC. In 2019 100% coverage of community midwives had been achieved (40,000 midwives in Sudan) according to the FMOH. The government believed that from a programme perspective, the community midwives were not delivering the standards needed in terms of the package of services they could offer, the duration and depth of their training, and the selection criteria around their admission to the programme. There was an ICM recommendation to upgrade the training of community midwives. The majority were not delivering with quality it seemed (through no fault of their own). The government suspended the community midwifery schools, developed the new diploma curriculum in 2018 and passed it to the FMOH, which approved it and passed it to the Ministry of Higher Education. The revolution then delayed things in 2019 and not too much moved forward. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |

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| <ul style="list-style-type: none"> • Then COVID-19 delayed things further in 2020. • Now, in 2021, there is every hope that the Ministry of Higher Education will approve it. • The Academy of Health Science, which helped develop the curriculum will host the course and award the diploma. | |
| <p>UNFPA support to midwifery skill building</p> <ul style="list-style-type: none"> • UNFPA has supported most of the midwifery capacity building programmes including basic and in-service training with provision of commodities and skill lab preparation. • Although there is no direct financial support to the midwives, UNFPA provides safe delivery kits to them in coordination with FMoH. • UNFPA through the Academy of Health Science, supported the midwifery schools on capacity building programmes providing skill labs for training, and support to both basic and in-service training. • A decision was taken to up the skills and capacity of midwives therefore through the development of a diploma programme and a three-year training course. UNFPA supported the Academy of Health Sciences to develop an academic diploma for midwives. The curriculum is now ready and approval by the ministry of high education is under process. • The ICM assessment, conducted in 2017 with support from UNFPA, identified the shortcomings in community midwife training. | <p>Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021</p> |
| <p>UNFPA activities in support of midwifery</p> <ul style="list-style-type: none"> • Pre-service training including midwifery diploma: • UNFPA supported finalization of the midwifery diploma curriculum which is pending the validation of the Ministry of Higher Education • Procurement of skill lab equipment for four states • Supported the bachelor (of nursing) programme through deployment of eight midwifery tutors and clinical instructors, and one obstetrician • 196 students enrolled and 32 were graduated in 2020 | <p>UNFPA and GoS, 2020 Annual Progress Report – 7th Country Program Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>Development of curriculum</p> <ul style="list-style-type: none"> • The curriculum was developed locally by national experts and the CO plans on having the curriculum reviewed by international experts. • Teaching staff in the ICM-like midwifery school was retained by provision of monthly salaries for eight midwifery tutors and one consultant obstetrician. • All are providing teaching services to the BSc midwifery programme and contributed to developing the midwifery diploma curriculum. | <p>UNFPA, MHTF 2018 Midyear Progress Report - Sudan, 2018, UNFPA, Khartoum, Sudan</p> |
| <p>Identification of inter-related midwifery investments for maternal health</p> <ul style="list-style-type: none"> • Over the last five years, findings from MDSR have generated actions by the National Maternal Death Review Committee (NMDRC) for both health system and community level, which contributed to progress in many forms of responses, which are centred mainly on improving health at facility, without considering interventions regarding first and second delays. | <p>UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, UNFPA Khartoum, 2019</p> |

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| Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education | |
| <ul style="list-style-type: none"> ● These interventions have led to improved quality of care through mobilization of additional resources, including training of midwives, availing of clean delivery kits, availing of delivery, and operating tables, equipped ambulances and essential drugs for emergency obstetrics care. ● Among these actions are improvement in midwifery services and management of emergency obstetric problems. ● There was increased coverage in midwifery services during the last five years, whereby the end of the year 2018 villages covered by midwives reached 96 per cent, the rest were not able to select their clients to join midwifery schools due to socio-cultural barriers. ● Only 48.7 per cent of community midwives were fully recruited into the health system while 43.5 per cent were receiving regular incentives from FMOH in collaboration with the Ministry of Social Affairs. | |
| Togo | |
| <ul style="list-style-type: none"> ● En matière d'environnement favorable aux sages-femmes, il y a eu deux pistes d'actions majeures. D'abord le renforcement de la formation des sages-femmes. Il y a eu des appuis qui ont été apportés aux deux écoles des sages-femmes. C'était deux au départ mais actuellement, il y en a dans chaque région. L'UNFPA avait appuyé ces écoles dans la revue du programme de formation selon les normes du LMD. Ce travail a été fait avec l'UNFPA en collaboration avec l'OMS en respect aux exigences du LMD. Ensuite, l'UNFPA a fourni du matériel pour la pratique. | UNICEF staff, UNICEF, June 2021, Togo |
| <ul style="list-style-type: none"> ● Depuis 2018, l'UNFPA a beaucoup contribué au renforcement des compétences des sages-femmes : Formation de 928 accoucheuses traditionnelles à la prise en charge des femmes vivant avec le VIH et renforcement des compétences des sages-femmes à l'amélioration de la qualité de l'accueil. | National staff, Midwives Association, June 2021, Togo |
| <ul style="list-style-type: none"> ● Pas un programme de formation continue. Chaque partenaire arrive en fonction de son domaine d'intervention et de son intérêt pour un programme de formation. Organisation des séances de renforcement des capacités des sages-femmes avec l'accompagnement de l'UNFPA. | National staff, Midwives Association, Togo, June 2021 |
| <ul style="list-style-type: none"> ● UNFPA a appuyé l'élaboration le cadre national de la pratique sage-femme il appuie chaque année la formation des maîtres et tuteurs de stages sur l'encadrement et finance la supervision des apprenantes sur les lieux de stage. | UNFPA staff, UNFPA, Togo June 2021 |
| <ul style="list-style-type: none"> ● Sur le plan de la formation initiale, le Togo dispose de suffisamment d'écoles de formation de sage-femme au niveau de chaque région administrative. Ceci demande une qualification adéquate des enseignants, mais ils sont souvent des moniteurs n'ayant pas de qualification élevée en obstétrique. Ailleurs, les écoles ne sont pas accréditées, et l'encadrement optimal du stage pratique des apprenantes souffre d'une inadéquation entre le nombre de sites capable d'assurer le stage et le nombre de stagiaires, qui est plus important de nos jours. ● Les sages-femmes sorties des écoles ne sont pas toutes recrutées par l'Etat qui demeure leur plus grand employeur. | UNFPA staff, UNFPA, Togo June 2021 |
| <ul style="list-style-type: none"> ● Ces formations nous aident dans nos prestations à donner un travail de qualité à nos femmes qui viennent demander notre soutien. Ça fait que nous avons un certain paquet qui nous permet d'être à l'aise dans le travail que nous faisons ; oui qui nous permet d'être à l'aise. Sinon il n'y a pas trop de références, nous pouvons prendre en charge beaucoup de choses par exemple en salle d'accouchement nous pouvons faire la ventouse au lieu de référer à chaque temps les femmes. Les références ont | Midwife, Government, Togo, June 2021 |

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| diminué, le travail aussi, la confiance des femmes a aussi augmenté (meilleure qualité des services offerts, diminution des références, amélioration de la confiance des femmes). | |
| <ul style="list-style-type: none"> ● La supervision individuelle se fait après la formation. Lorsque nous recevons la formation, un semestre après, nous recevons une supervision. Mais en général, il y a une supervision à chaque niveau qui vient au niveau de la maternité. Le niveau central vient par exemple en supervision PF, en supervision consultations prénatales (CPN)... Là, c'est tout le personnel qui est impliqué. Ces supervisions se font au moins une fois dans l'année (supervisions semestrielles après formation ; supervisions annuelles pour tout le personnel). | Midwife, Government, Togo June 2021 |
| Uganda | |
| Responding to national needs <ul style="list-style-type: none"> ● The main contribution of UNFPA is leadership on midwives and towards ensuring that midwives are increased in numbers. Their efforts to train and deploy midwives has improved competencies and to provide better maternal, newborn and child health (MNCH) services. ● They are training anaesthetists under the ANSWER programme, as this is one of the key gaps. Women who need C-sections must be referred to higher level facilities because there is no anaesthetist. | Interview, Bilateral donor. Kampala. May 2021. |
| UNFPA support for quality midwifery education <ul style="list-style-type: none"> ● UNFPA has supported the improvement of quality of midwifery education via “training of 60 midwifery tutors, equipping midwifery skills labs and libraries in 20 midwifery training institutions, updating the midwifery curriculum to conform with International CICM and WHO guidelines, introducing the Structured Collaborative Clinical Training, conducting career promotion in secondary schools to inspire girls join midwifery as a career of choice; supporting the UNMC to decentralise its regulatory functions to 13 regional centres in order to improve on the registration and license renewal processes, supporting midwives to establish an association to improve on professional development, building capacities of the health workforce to provide quality SRHR services, equipping health facilities and strengthening the policy and legal environment under which midwives and other health workers operate in Uganda.” | UNFPA Uganda. Population matters Issue Brief 13. 2020, p.2 |
| <ul style="list-style-type: none"> ● With support from MHTF, “the Ministry of Education through the Teachers Instructor and Education Training Department conducted a joint monitoring and support supervision in 15 Health Training Institutions. The institutions were assessed and ascertained on the use of equipment in the skills labs, use of the libraries by the students and provision of mentoring and coaching to students in the skills labs and practicum sites on facilities for skills acquisition especially skills labs and the practicum sites and finally provided technical guidance and recommended further improvement.” | UNFPA Uganda, UNFPA-MoES Annual Workplan Progress Report, 2018, p.14 |
| <ul style="list-style-type: none"> ● “The Ministry of Education was supported to train 20 clinical preceptors on Structured and Collaborative Clinical Training Programme (SCTP) for 20 EmONC Training sites to make a cumulative total of 60 with trained preceptors in this methodology for both 2019 and 2020. In addition, the Ministry through the Business, Technical, Vocational Education and Training (BTJET) conducted a workshop and developed training manuals for midwifery diploma and midwifery extension.” (p.3) ● The goal for 2020 was to train 30 clinical preceptors; however, it was not possible due to COVID-19 restrictions. | UNFPA Uganda, Final Annual Report for MHTF, 2020 |

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education

- UNFPA has contributed to the quality of midwifery education by supporting the revision of the midwife curricula, shifting from a subject-based to a competency-based curriculum. This has contributed to improving the quality teaching and facilitated “easy testing and assessment of learning”, although it is too early to say whether it has improved the competencies of the students (implementation only started in 2019 and was paused due to COVID-19-related closure of schools). “The curriculum guides very well – it is easier than before when the teachers were defining the assessment areas and it was not clear what they should or how to assess. The new curriculum shows clearly what a Year 1 student is supposed to know and able to do. It is also stated exactly what equipment, learning materials and human resources are needed for teaching this competency.”
- UNFPA has also **supported scholarships for teachers in midwifery schools – bringing them back to the college to become “tutors”** (i.e. teachers), and once the education is completed, they go back to their teaching institution. “That has been a huge contribution of UNFPA – those sponsorships.”
- Support was given to implement the **“Structured Collaborative Clinical Teacher Training Programme,”** a six-day training module to train preceptors – i.e. mentors based in the clinical areas in the hospitals responsible for supervising and teaching the midwifery students/interns. “In the past, some of them were not prepared to teach – but this model teaches those preceptors how to teach the students, to become good midwives.” The interviewee considered this one of the most significant contributions of UNFPA to midwifery in Uganda.

Interview, MoES, Kampala, May 2021.

Bridging the gap through recruitment, bonding and deployment of midwives:

- UNFPA helped to bridge the gap in midwifery. In 2015/2016, there were few midwives in facilities. UNFPA helped to identify and recruit nurses, provide scholarships and send them to midwifery schools for further training. “We see those midwives when we go to the field.” In addition, the support for GIS within the public system is providing information about the deployment of midwives and nurses, and “responds to all our questions.”
- Overall, UNFPA has contributed to midwifery in Uganda and its efforts have yielded **positive results**. There have been some **challenges in the hiring/deployment of the UNFPA-sponsored midwives in some of the districts**. The **bonding programme** was supposed to improve staffing of midwives in Uganda in different districts by encouraging girls with low education at community level to become midwives. “We see that in Karamoja it really developed, and many of them were picked up and hired by the District Service Commission. But in some districts (other regions), it did not work – and this was because there were limitations on government, on how many midwives they can hire from the UNFPA programme, into those facilities. My personal opinion, this is a sustainability issue, how to make sure we collaborate with government to make that transition – from UNFPA to become hired by government. Maybe it worked in Karamoja because there was such a huge gap? I am not sure.”
- Regarding the **recruitment and retention of bonded midwives, delays have occurred due to the limited wage bill ceiling** allocated to the districts. However, the MoH has conducted annual emergency recruitment drives for health workers, which has helped to absorb the bonded midwives. **The lack of government funding to take the midwives on and pay salaries remains an issue.**

Interview, NGO partner, Kampala, May 2021

Interview, Bilateral donor, Kampala, May 2021

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education

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| <ul style="list-style-type: none"> ● UNFPA supports training for midwives in schools, mentoring for midwives, and award for the best performing midwives, in partnership with Sweden Embassy (Sida). ● There are currently no other partner/donor supporting midwifery education and practice than UNFPA/Sida. AMREF used to provide some support in the past, but no longer. ● The most significant gap is training of a sufficient number of skilled midwives, and if additional funding becomes available, it should be used for training more midwives (e.g. through sponsorships and support to midwifery schools) and deploying them in underserved areas where access is limited | <p>Interview, MoH national staff, Kampala, May 2021</p> |
| <ul style="list-style-type: none"> ● UNFPA support for capacity development/midwifery education and training: MCH used to be a huge challenge in the district; this used to be a very large district before the division into several smaller districts. It lacked skilled midwives that used to be the biggest gap. UNFPA has provided capacity building for newly trained health staff/midwives. ● UNFPA sponsored the education of 17 midwives for the district, those midwives that were trained were selected by Gulu District Local Government and were sent to different midwifery school and hospitals across the country (even in Kampala) – and then they came back to work in Gulu (after end of education). That is how UNFPA helped “lift” the human resources and helped to have skilled deliveries in health facilities, even Health Centre (HC) II – UNFPA supported training, when they came back, local government funded their salaries. UNFPA funded 3-year a training of midwives. ● The UNFPA-supported 17 midwives are now deployed in government structures or for private, not-for-profit providers (PNFP). They are all working, both government and private facilities. They finished in 2018/2019. Even some are now planning to go back for diploma – they were only “certificates”. | <p>Interview, MoH staff, Gulu District, Uganda, May 2021</p> |
| <ul style="list-style-type: none"> ● UNFPA has provided support for training and sponsoring midwifery students since 2007. The Midwifery School in Agagao has received support since 2011 (teaching equipment; still in use today). Since 2015, UNFPA has supported girls from poor/disadvantaged districts to attend midwifery education (certificate). The districts lead the selection of students, who receive tuition and support and are then bonded for two years to return to the district. ● The school received textbooks for the library for use by tutors and students, which facilitated teaching. UNFPA also supplies equipment for the skills labs, i.e., models, which improved the performance of students through demonstration and practice. In addition, a school bus was provided to support community outreach to hard-to-reach areas. The bus is used to take students to the community for two weeks for practicums as well as for integrated outreaches and national seminars at specialized hospitals. ● UNFPA has also helped with mentorship, e.g., supported staff from the school to go to AMREF in Kenya for training of trainers in mentorship. (Note: this was in 2014.) ● UNFPA is different than other donors/partners as they focus on sponsoring and deploying trained midwives to the hardest-to-reach areas, which helps save the lives of mothers and babies in those areas, as the women would otherwise not have access to a skilled midwife (without UNFPA support). “With the students sponsored by UNFPA, they send them to places where there is really a need for them to be, in areas that are hard to reach, they ask them to go back there to work. These students are really working hard, with their heart, being appreciated by the communities. UNFPA put as a condition that they must go and | <p>Interview, government official, Agagao District, May 2021</p> |

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| Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education | |
| work in very hard to reach areas – and that is of great benefit to that community. Not necessarily back to their own district, but in areas of greatest need. UNFPA takes the service far to those who need it the most.” | |
| <ul style="list-style-type: none"> ● UNFPA has provided scholarships for poor young girls to become midwives in the Karamoja sub-region, which they said has helped increase access to skilled midwives among disadvantaged and poor women. ● School books and other materials are provided for those students and the midwifery schools. ● The interviewees noted that districts usually have the funding to hire those midwives; the issue is rather attracting and retaining skilled midwives to come and work in remote areas, like Karamoja. The scholarship programme, using midwife students coming from those areas, has been successful in filling vacant midwifery positions in those areas, and retaining the midwives even after the bonding period ends. ● “The biggest contribution is the training of preceptors (80 trained with UNFPA support) as they are mentors in health facilities and transfer skills to students. Support is funding, but not technical assistance. I went to Karamoja, deep down there, and saw students (sponsored by UNFPA) doing midwifery at a maternity hospital. I think it is very important, because these students are from there, and they will go back to serve there. It has been so hard to get people to go there and work. So, if we target more of these hard-to-reach places and train people to go back to those places, it is really good. Government has the funding to hire them; the issue is recruitment.” | Interview, MoES, Kampala, May 2021 |
| Zambia | |
| Midwifery Curriculum Development and Review | |
| <ul style="list-style-type: none"> ● The General Nursing Council is responsible for curricula review. With support from MHTF, it reviewed four midwifery curricula and developed a BSc Midwifery curriculum that would prepare a well-trained and knowledgeable midwife to provide critical and effective maternity care. The MoH developed a pre-service Midwifery Mentorship training package for use in Midwifery schools to mentor students. (This was a follow-on to support provided by MHTF in 2015 to train five senior midwifery educators and supervisors as trainers of mentors.) ● In prior phases of MHTF (between 2014-2017), UNFPA supported the training and deployment of 230 midwives to work in rural areas in three UNFPA-supported provinces contributing to increased availability of skilled birth attendance at delivery. | UNFPA Zambia. MHTF Achievements 2018-2020. Undated. |
| <ul style="list-style-type: none"> ● UNFPA provided technical and financial support to the MoH to revise the midwifery curriculum to align with international standards and to incorporate emerging issues such as GBV, adolescent health and people living with disabilities. In addition, Respectful Maternity Care Guidelines were adapted to foster quality of care during pregnancy and childbirth. | UNFPA Zambia. 2019 Annual Report. 2020. |
| <ul style="list-style-type: none"> ● UNFPA efforts to advocate for “First Time Young Mother” issues in the midwifery curriculum were deemed by MoH to be already included within general interventions for safe motherhood and teen pregnancy. Therefore, in 2019 there were no significant changes at national level to impact on this thematic area for UNFPA. | UNFPA Zambia. MHTF 2019 End of Year Annual Report |
| <ul style="list-style-type: none"> ● Through UNFPA technical and financial contribution to MoH, the midwifery curriculum was revised to be aligned to international standards and incorporate emerging issues such as GBV, adolescent health and people living with disabilities, aimed at improving the quality of midwifery training and provision of quality Sexual Reproductive Health (SRH) services. In addition, Respectful Maternity Care Guidelines were adapted to foster quality of care during pregnancy and childbirth. | UNFPA Zambia. 2019 Annual Report. 2020. p.2 |

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| Further, within the context of advancing equity and leaving no one behind, a disability inclusion module for pre-and in-service training of health care providers was developed, and selected information, education and communication materials developed in Braille to facilitate provision of SRH information to persons with visual impairment. | |
| Strengthening capacity through training, mentoring and supervision <ul style="list-style-type: none"> Through MHTF, UNFPA Zambia procured midwifery teaching models, set up clinical skills laboratories, strengthened skills of tutors (ToT), supported educators’ forums for skills and updates. Most important was the financing of the training (tuition fees) in one-year in-service course at midwifery schools in the three UNFPA-supported provinces to increase the number of skilled birth attendants. However, the issue of human resources is critical; “you have a bucket with a hole that water is seeping through. You can never say there are enough human beings. People leave basic Midwifery for more education, leave the public sector. So there is always a need for training for MWs; needs to be on-going.” The midwifery and nursing professions have been upgraded with the introduction of the midwifery programme where someone can come straight from high school without first becoming a RN. Mentoring and supervision can still go on without UNFPA support. Most institutions cry for equipment which would make support more sustainable as you can guarantee that most equipment will be there for 5 years. Through the FCDO programme in Western and Central Province, selected facilities have had equipment procured for EmONC services; however, this has been discontinued due to the funding cuts from the UK. | Interview, UNFPA Zambia staff. August 2021. |
| <ul style="list-style-type: none"> In terms of capacity building, UNFPA has been very helpful supporting programmes for mentorship and skills for health workers. In training, for example, UNFPA supported short courses to increase the availability of midwives. “Human resources are a big problem for us, especially a shortage of midwives. In the provinces where they support us, we are able to work with them to identify nurses that are willing to undergo a training to become midwives and they undergo training.” | Interview, MoH Zambia staff. August 2021. |
| <ul style="list-style-type: none"> In 2018, 80 midwives were trained; 117 health care providers acquired skills and knowledge to provide basic EmONC services for mothers and their newborn babies. | UNFPA Zambia. 2018 Annual Report. 2019 |
| Development of a comprehensive, curriculum for midwifery <ul style="list-style-type: none"> The MoH benefited from UNFPA funding as a regulator for curricula development and review. Previously, there were five different curricula for midwifery, and UNFPA supported the review and revision into one, comprehensive curriculum. “We had too many curricula; it caused confusion. Prior to this, one had to be a nurse to become a midwife. Not anymore, we now have midwives who start from high school and go straight into the midwife programme (3.5 years). UNFPA was handy to help evaluate this programme. [We have] just concluded the evaluation and now are revising the comprehensive curriculum. We will now have one curriculum that caters to everyone at each point. We came up with a road map to review; UNFPA supported a situational analysis about 1.5 years ago. Through situation analysis, we know what exists and what are the gaps. UNFPA sponsored a stakeholder consensus meeting to consult with others who were important. From there, we had another meeting for content realignment and add new concepts needed new content to add to core competencies. All these meetings were quite important to get the views of people.” | Interview, MoH staff. Lusaka, Zambia. August 2021. |

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| <ul style="list-style-type: none"> Unfortunately, the COVID-19 pandemic disrupted the road map. There are efforts underway to determine how to move forward with the validation meeting. Once this is done, there is the need to develop training materials, i.e., procedure for observations, procedure manuals, learner, and training guides. The process is lengthy, and it is halfway there for the comprehensive curriculum. UNFPA provides “double barrel support.” They provide financial resources and technical expertise; they have helped to define the competencies and aligned with international standards. Once the current curriculum process is complete, the government agency established for quality assurance will call for a mid-term and five-year revision to incorporate new training issues/create addendums. There will be a need to do gap analysis, consult stakeholders, etc. It is a continuing process; it is one thing to do a curriculum, another thing to implement it. There is a need to take the teachers through the process. “Research is needed to make the implementation science come to fruition.” Quite a lot of concept writing is to come back to UNFPA to deal with a particular issue. For example, future issues include: a rise in terms of key populations (“important for us – something there and people do not talk about it; need to see how nurses are appreciating it”); sign language, meant for a few, but now it is included in the curriculum. “We still need to do the M&E to see how things are executed and to produce as much data as possible so that we can make decisions based on evidence.” | |
| <p>Support for Midwifery Schools, including tuition support for midwives</p> <ul style="list-style-type: none"> Funds are also used to support the training of midwives as skilled attendants. MHTF has supported tuition fees for nurses to ensure that nurses are trained according to international standards and stay in their home areas after training. Resources were provided to do the training, including demonstration models (Mama Natalie). The schools have been supported so that they have access to technology; for example, the school in Western Zambia was given textbooks for library and computers that can aid students in doing research on assignments. | Interview, UNFPA Zambia staff. August 2021. |
| <ul style="list-style-type: none"> The MoH receives support for the training of midwives, especially in the areas that UNFPA is supporting. “This is good for us because they try to help us recruit local people from that particular area so that it's easier to retain them. So, we do have midwives trained in some of these provinces and it ups the numbers in those provinces for trained midwives.” | Interview, MoH Zambia national staff. August 2021. |
| <ul style="list-style-type: none"> Apart from orientation, mentorship, and supervision, UNFPA has helped in the sponsorship of midwives in our facilities within Western Province. They not only sponsored midwives for one year’s training but also built capacity and skills to the tutors in the Midwifery college, they have provided books on midwifery to the college, they have provided equipment and models for the students to use and practice on and sharpen their skills and knowledge. | Interview, MoH staff. Western Province. August 2021. |
| Online survey | |
| <p>Question 6: Extent of agreement with UNFPA contributions/results in midwifery</p> <ul style="list-style-type: none"> Survey respondents overwhelmingly agreed/strongly agreed (88 per cent) both of the following statements: <ul style="list-style-type: none"> UNFPA support to strengthen midwifery pre-service education is technical sound, based on global standards, and aligned to national needs. | |

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| <ul style="list-style-type: none"> ○ UNFPA support to strengthen midwifery in-service training and education programmes is technically sound, based on global standards, and aligned to national needs. | |
| Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support | |
| Indicators: | |
| <ul style="list-style-type: none"> ● Examples of UNFPA-supported costed strategic action plans for midwifery associations ● Examples of UNFPA-supported communication, advocacy and resource mobilization activities geared to strengthen capacity of midwifery associations ● Examples of capacity building actions by midwifery associations to provide continuous professional education, to build capacity of young midwifery leaders and to provide improved access to quality SRHR information by adolescents through social and traditional media ● Views and experiences of global and national leaders and members of midwifery associations regarding relevance, effectiveness, and efficiency of UNFPA efforts ● Plans to sustain capacity building efforts within midwifery associations are in place and being implemented. | |
| Observations | Sources of evidence |
| Global | |
| <ul style="list-style-type: none"> ● UNFPA has helped its regions to understand how to work with the midwifery associations. They have strengthened many national midwifery associations through different projects at regional and country level. The lever is at the global level through the annual partnership with ICM. For example, the collaboration on the SoWMy, the Lancet article in 2019, have had an enormous impact. ● Support for the global ICM congresses has been great; sponsored midwives to attend from low-income countries. ● MHTF is unique; hard to think of another fund that is dedicated to MNH. The thematic fund gives MNH a priority that is recognized within UNFPA and by its partners. Without it, where would be the voice for midwives; ICM cannot do it alone. WHO cannot do it. It would help to have a midwife at a high level in the organization. | Interview, implementing partner, September 2021. |
| Regional | |
| <ul style="list-style-type: none"> ● No observations | |
| Bangladesh | |
| <ul style="list-style-type: none"> ● Continuing to build on the compendium of good practices in midwifery, two new good practices were documented: a young midwifery leader programme in Latin America and a mentorship programme in Bangladesh. The MHTF has documented 15 good midwifery practices to date that are shared through South-South exchanges and learning. | The MHTF UNFPA, Annual Report 2019, 2020, p. 12 |
| Benin | |
| <ul style="list-style-type: none"> ● Appui à la célébration de la journée des sage-femme – mobilisation et porter l’attention sur la pratique et les défis. UNFPA a recruté un consultant qui a aidé le développement du Plan Stratégique Pluriannuel 2016-2020. Dotation d’outils de gestion portables pour gérer l’association | Entretien, UNFPA bureau pays, Mai 2021, Benin |

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| Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support | |
| <ul style="list-style-type: none"> • Mais le Plan n'a pas été mis en œuvre ou décliné en plans d'action annuels. Les seuls appuis sollicités étaient pour organiser des événements ponctuels (tels que le dépistage des cancers génitaux et requetés pour participer à des rencontres internationales). • Appuis ad-hoc et pas structurels... | |
| Sudan | |
| Communications and awareness raising <ul style="list-style-type: none"> • Celebrations held with UNFPA support to commemorate the International Day of the Midwife, which was important to do in order to raise awareness about the midwife, the role of the midwife and the new process underway to strengthen midwifery training and guidelines. | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |
| The Sudan Midwifery Association (SuMA) <ul style="list-style-type: none"> • SuMA was founded under close supervision of the Academy of Health Sciences and is now hosted and technically supported by it. • Still working on ICM registration, which is yet to completed • UNFPA contributed on the foundation of SuMA although more technical and financial support are required. | Interview, National Policy and Teaching Partner, Khartoum, 3 June 2021 |
| ICM support to Sudan <ul style="list-style-type: none"> • Reforming and supporting midwifery in Sudan. • Working on regularisation and professionalisation of midwifery through SuMA as well as through the diploma curriculum and training standards. • ICM engaged to celebrate International Day of Midwifery and raising the profile of midwifery in Sudan. | Interview, UNFPA Khartoum, 9 June 2021 |
| SuMA <ul style="list-style-type: none"> • Midwives happy about the establishment of the association. Waiting for registration from the ICM. • No individual midwifery contributions made yet (or registration) • SuMA is hosted by the Academy of Health Sciences which provides space for meetings, offices and so on. | Interview, Research/practitioner, Khartoum, Sudan, 15 June 2021 |
| Midwifery Association <ul style="list-style-type: none"> • One national Midwives Association established which includes both sister midwives and health visitors. • A constitution – based on national standards – is being developed by a national consultant. • The necessary documents for the registration are cleared by the Humanitarian Aid Commission. The association General Assembly meeting is planned during the last week of December. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| Associations at the state level <ul style="list-style-type: none"> • UNFPA support includes technical and financial assistance to the midwifery associations at State level to conduct their regular meetings and build their capacities and organizational arrangements. | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |

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| Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support | |
| <ul style="list-style-type: none"> UNFPA assistance for the implementation of costed plans of the national and state midwifery associations “to support the development of the EmONC network. Due to the COVID-19 context, and the competing priorities of the country to respond to the pandemic, the activity is planned to be implemented as part of third tranche. As well it is attributed to the finalization of the prioritization report”. | UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan. p.4 |
| <p>UNFPA support to SuMA</p> <ul style="list-style-type: none"> UNFPA supported the foundation of the SuMA. During this process UNFPA provided both technical and financial support. They are still waiting for the ICM registration of the association and recognition of its sufficient professional standard to join. SuMA has the proposed role to support increased professionalisation of midwives across the system and to start improving quality of care everywhere but especially in rural and underserved areas | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| <p>Building midwifery as a career</p> <ul style="list-style-type: none"> Engaging young midwives is instrumental for improving the midwifery profession and leadership. UNFPA will continue to support the young midwives and promote their role in SRHR through the new midwifery reform process. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| <p>UNFPA is the main counterpart to FMoH addressing MNH and SRH issues.</p> <ul style="list-style-type: none"> UNFPA support to midwifery programmes includes supporting policy development, capacity building programme, midwifery diploma, foundation of the SuMA, provision of midwifery KITS, and supports supervision visits. | UNFPA Country Team initial evaluation group discussion, 5 June 2021, Khartoum |
| Togo | |
| <ul style="list-style-type: none"> Midwifery : Le FFM a permis avec la collaboration de l’UNFPA, du Ministère de la Santé et l’ASSAFETO : <ul style="list-style-type: none"> La célébration de deux premiers bébés 2020, de leurs mères et des sages-femmes ayant accouché dans la région Maritime et des Savanes. La célébration de la journée internationale de la sage-femme le 05 Mai 2020 qui a été marquée par (i) le soutien psychosocial des sages-femmes en exercice par les paires séniors; au total 400 sages-femmes et accoucheuses ont été soutenues dans leur travail en contexte de la Covid-19, (ii) 40 émissions radiophoniques dans toutes les régions sanitaires du Togo, (iii) la production d’affiches et banderoles de sensibilisation sur les soins de sage-femme et la lutte contre la covid-19, (iv) une vidéo réalisée sur la pratique sage-femme dans le contexte de la Covid-19 et diffusée sur la télévision nationale La reconnaissance de 12 meilleures sages-femmes distinguées pour leur travail dans une Cérémonie apothéose de Célébration de l’Année de la sage-femme et de l’Infirmier, couplée avec un plaidoyer pour le recrutement des SAGES-FEMMES se fondant sur des données collectées sur la situation des SAGES-FEMMES au chômage La production des données sur les sages-femmes au chômage, l’élaboration d’un document de plaidoyer et de deux projets de mobilisation des ressources pour le renforcement des écoles de formation des sages-femmes et de l’ASSAFETO | UNFPA, MHTF Request Proposal 2019-2022, 2019, p.5 |

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| <ul style="list-style-type: none"> ○ La confection de 1200 blouses, 1200 coiffes, 2400 bavettes réutilisables MMT95 pour 600 sages-femmes travaillant dans les maternités du Togo. | |
| <ul style="list-style-type: none"> ● L'objectif général de cette opération consiste à améliorer la connaissance des participants en matière de protection des droits des femmes à travers diverses activités, puis favoriser la réalisation d'une synergie au sein du corps des sages-femmes afin de mieux intervenir dans les communautés. ● Objectifs spécifiques - Organiser une caravane de lancement de l'évènement au sein de la ville de Kara - Réaliser un micro-trottoir sur les connaissances/perceptions de la population sur les droits de la femme. Organiser une conférence inaugurale de célébration de la JISF - Sensibiliser la population sur la prévention du cancer du col chez la jeune fille (9 à 12 ans) par la prévention des infections sexuellement transmissibles. Discuter sur le plan de carrière des sages-femmes, Communiquer sur les droits des femmes (parturientes, sages-femmes et patientes) à travers un panel thématique avec deux sages-femmes et un membre de Amnesty International. Réaliser une soirée culturelle animée par les sections régionales de l'ASSAFETO. III. ● Résultats attendus - La caravane à travers la ville de Kara pour annoncer l'évènement est réalisée. Une discussion sur le plan de carrière des sages-femmes a été réalisée, L'élément : micro-trottoir sur la perception des droits de la femme par la population est réalisé. La conférence inaugurale est réalisée. La sensibilisation de masse sur la prévention du cancer du col de l'utérus chez la jeune fille (9 à 12 ans) par la prévention des infections sexuellement transmissibles est réalisée. Le Panel sur les droits des femmes (parturientes, sages-femmes et patientes) avec deux sages-femmes et un membre de Amnesty International Togo est réalisé. - La soirée culturelle est animée. | Association de sage-femmes du Togo, Rapport des Activités, 2019, p.3 |
| <ul style="list-style-type: none"> ● Parallèlement aux renforcements des capacités des écoles de formation, l'UNFPA a appuyé l'association des sages-femmes (ASSAFETO) dans le renforcement des capacités en leadership. Ils ont fait un formidable travail là-dessus. Ils ont soutenu la formation des sages-femmes surtout à l'extérieur pour leur permettre non seulement d'aller apprendre mais aussi d'aller exposer les bonnes pratiques qu'elles ont développées. Donc sur les ressources humaines, l'UNFPA a fait un gros travail et continue d'y travailler. | UNICEF staff, UNICEF, June 2021, Togo, pp.3-4 |
| <p>UNFPA support to build the capacity of midwifery organizations/associations</p> <ul style="list-style-type: none"> ● Support for the participation of the bureau in meetings, in the drafting of texts for the Federation of Midwives Association of Francophone Africa (FASFAF). The action plans of the Association developed regularly with the support of UNFPA, renovation of the Maison de la Sage Femme to make it a centre for in-service training and internship. ● Participation in the 2nd congress of FASFAF. | UNFPA staff, UNFPA, June 2021, Togo, p.5 |
| <p>Objectifs de la FASFAF</p> <ul style="list-style-type: none"> ● Général l'objectif principal dudit congrès est d'amener les associations de sages-femmes d'Afrique francophone à partager leurs expériences et à harmoniser leurs actions pour répondre à la vision 2030 de la pratique de sage-femme. ● Spécifiques. Echanger sur le rôle de la sage-femme et sa place dans la communauté, dans un contexte de partenariat actif pour l'amélioration de la santé de la reproduction. Discuter des enjeux de la formation et d'innover dans la construction des compétences des sages-femmes pour répondre au besoin universel des 46 interventions essentielles de santé de la mère et du | UNFPA, Rapport de Mission, 2018 |

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| nouveau-né. Partager les meilleures pratiques pour la promotion du bien-être du couple mère-enfant et de toute la famille. Valider le plan stratégique triennal de la FASFAF pour la période. | |
| <p>Appuyer la supervision des apprenantes Sage-Femme par les monitrices</p> <ul style="list-style-type: none"> ● Résultats attendus : 60 Etudiantes de deuxième année et 60 autres de la 3^e année ont été supervisées ● Statut : Non réalisée * ● Commentaire : Perturbation de l'année scolaire par la pandémie à Coronavirus <p>* Commentaire du bureau de pays : L'activité de supervision est en cours depuis 3 ans, c'est l'année 2020 seulement que cette activité a été perturbée. Mais elle demeure une activité régulièrement menée</p> | UNFPA, MHTF Request Proposal 2019-2022, 2019 |
| Uganda | |
| <p>Strengthening capacity of the UPMA</p> <ul style="list-style-type: none"> ● UPMA with MoH followed up and mentored 20 private midwives and their co-workers at maternity homes for those who received midwifery kits from UNFPA in northern Uganda and Teso regions. Midwives were mentored on EmONC and their role in the community. Findings from the mentorship included: <ul style="list-style-type: none"> ○ 90 per cent of maternity homes/ clinics need remodelling to ensure standards improve privacy and infection prevention. ○ Only three midwives had updates on long-acting contraception and only one had the skill to insert postpartum intra uterine device (IUD). ○ In most health facilities, midwives needed skills for handling emergencies like PPH, neonatal resuscitation and Eclampsia. ● A 3-day training on long-acting contraception was conducted from Soroti district in December 2018 for 20 private midwives from UPMA. The training included theory and practical sessions at the regional referral hospital. | UNFPA Uganda, 2018 Annual MHTF Report, 2018 |
| <p>Strengthening capacity of the NMAU:</p> <ul style="list-style-type: none"> ● "In 2020, the NMAU developed a costed strategic plan 2020/21-2024/25. This is the first strategic plan of the association which outlines the strategic vision and goals that have been identified to help the Association of Midwives realize its full potential and fulfil its mission to serve the Ugandan citizenry as well as the wider community as global citizens. An additional 72 midwives were enrolled into the association during the International Day of the Midwife (IDM) celebrations at various health facilities. This makes a cumulative total of 326 members of NMAU." | UNFPA Uganda, Final Annual Report for MHTF, 2020, p.3 |
| <ul style="list-style-type: none"> ● UNFPA provided support to hire a consultant to lead the development of the NMAU strategic plan. An inception report was presented to a multi-sectoral Advisory Committee at the MoH, and comments were incorporated into the draft strategic plan. UNFPA also supported capacity building to register nurses and midwives into the GIS in 9 additional districts. | UNFPA Uganda, GoU/UNFPA Country Program Support to MoH 2019 Annual Workplan, 2019 |
| <ul style="list-style-type: none"> ● The Final Strategic Plan for the National Midwives Association of Uganda was available for printing and dissemination in the final two quarters of 2020. | UNFPA Uganda, MHTF Mid-Year Report, 2020 |
| <ul style="list-style-type: none"> ● MHTF supported the establishment and registration of a midwives' association that covers midwives working in the public, private and not-for-profit sectors. Prior to this, there was only an association working with private midwives. MHTF supported the development of its strategic plan, which will be printed and disseminated in 2021. | Interview, UNFPA Uganda staff, May 2021 |

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| <p>Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support</p> | |
| <ul style="list-style-type: none"> ● It is a young association and membership needs to be boosted. “They need to do a lot of recruitment and one of the things that MHTF supports is the IDM to ensure that more midwives are recruited during these events. This was a challenge in 2020 and the number of midwives who could join was very limited.” ● “Right now, the support is not only from UNFPA, but they (i.e., the midwives’ association) have solicited some support from AMREF and Rotary Club of Kampala – and they are now conducting some CPD (Continuous Professional Development) sessions for midwives around the country. They do mentoring, they train midwives on different midwifery processes to improve the standards and the quality of care that midwives provide. They are supporting this CPD across the country and they “put a good image to the midwives.” Sida supports “midwife-led activities” – where the midwives are very key. So, they go in the communities to promote midwifery activities, they talk on radio and TV, they encourage others to become midwives. They do a lot to bring light to the midwifery in Uganda.” | |
| <ul style="list-style-type: none"> ● The 2019 IDM was celebrated under the theme “Midwives, defenders of Human Rights.” The MoH with support from UNFPA and in collaboration with the NMAU, the UNMC, stakeholders, and other nursing and midwifery bodies organized the IDM celebrations and its pre-event activities in Mbarara district. ● Activities included midwife-led blood drives and career promotion, provision of reproductive health services via camps (family planning, cervical cancer screening), radio talk shows, community mobilization through schools and a film van, advocacy meetings with host district leaders, a midwives’ symposium (with 18 partner exhibits), and the placement of midwifery stories in the media. ● Recommendations for future IDMs, include reaching out to more partners, CSOs, ministries and stakeholders to support and participate. | <p>MoH Uganda, Report of the IDM 2019, 2019</p> |
| <ul style="list-style-type: none"> ● Conducting these annual days is a “political deal, a landmark, to show him or herself, similar to producing lots of t-shirts! If you repeat the same message every day, and every year, it means that this is implementation. It is a necessary evil – in the sense that we are not NGO or bilateral – we cannot say “stop this”, we do not have any choice.” | <p>Interview, UNFPA Uganda staff, Kampala, May 2021</p> |
| <p>Zambia</p> | |
| <p>Regional Conference on Midwifery</p> <ul style="list-style-type: none"> ● UNFPA supports the IDM each year to raise awareness about the critical role that midwives play in protecting maternal and reproductive health. ● In 2019, the 4th ICM Africa Regional Conference was held in Windhoek, Namibia in September 2019. The theme for the conference was “midwives leading the way for quality and equity in Africa,” speaking to the challenges of delivering midwifery care in the vast and sparsely populated countries. The meeting was conducted by ICM in collaboration with UNFPA and Swedish International Development Agency (SIDA) and attended by 250 participants, including 8 public and private sector participants from Zambia. The UNFPA Global Midwifery Strategy 2019-2030 was launched at the regional meeting. ● In conjunction with the meeting, a training workshop was held on “Essential Care for Labour and Birth” (ECL&B), as well as two pre-conference activities. | <p>UNFPA Zambia Mission Report: ICM Africa Regional Conference, Windhoek, Namibia. 2019.</p> |

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| <p>Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support</p> | |
| <ul style="list-style-type: none"> As 2020 was declared as the “Year of the Nurse and Midwife,” UNFPA COs received guidance at this meeting on how to showcase the work being done around midwifery to make the case for use in advocacy and resource mobilization “for the MHTF” and for writing excerpts for use in the State of World Midwifery report. | |
| <p>International Day of the Midwife - 2019</p> <ul style="list-style-type: none"> The commemoration of the IDM was hosted by the Luapula Provincial Health Office in May 2019. The Minister of Health opened the meeting which was attended by 88 midwives. | <p>UNFPA Zambia. MHTF 2019 End of Year Annual Report. Undated.</p> |
| <ul style="list-style-type: none"> The Minister of Health opened the 2019 IDM in Luapula Province (Mansa District), which was attended by the Provincial Minister, the Permanent Secretary, the District Commissioner, the ZUNO president, the UNFPA Country Representative, and the MAZ president. Awards were presented to 30 midwives from around the country for their contributions to maternal and child health (MCH) services. MAZ presented to the province donations of Neonatalie (demonstration model) and the Anti-shock garment for use in midwife education. The IDM theme in 2019 was “Midwives Defenders of Human Rights.” | <p>UNFPA Zambia. Report on Scientific Conference and IDM. 2019.</p> |
| <p>International Day of the Midwife - 2018</p> <p>The IDM theme in 2018 was “Midwives leading the way with quality of care” to highlight the role midwives play in assuring quality and respectful care. The IDM included a scientific meeting to share successes, challenges and the way forward in midwifery services. It was attended by MoH programme staff and directors, and partners from UNFPA, Jhpiego and PATH. The meeting was held in Livingstone and was attended by 196 midwives from 10 provinces.</p> | <p>UNFPA Zambia. Mission report: Midwives Scientific Meeting and Commemoration of the 2018 IDM (draft). 2018.</p> |
| <p>Support to the Midwives Association of Zambia</p> <ul style="list-style-type: none"> MAZ was formed in 2011, with the first elected members of the national executive supported by UNFPA. Before, it was an interest group under the union of nurses, but then the organization was formed and received support from UNFPA. There is only one midwifery association in Zambia with 1,000 members, although there are 4,000 midwives in country. It is voluntary membership. MAZ submits a workplan every year for UNFPA support. For example, UNFPA has supported the development of the strategic plan, annual commemorations to celebrate the IDM every year, scientific meeting every year, and other activities such as post-abortion care (PAC) trainings. UNFPA worked with MoH to advocate for MAZ to sit on the MPDSR national platform with UNFPA, in order to contribute to the discussions that are having to do with maternal and neonatal deaths. It also sponsored some members of the Association to international conferences, Africa ICM conference; supported MAZ to participate in development of respectful maternity care guidelines, “the first of its kind in Zambia.” UNFPA supported training in respectful maternal care in the provinces that they support (Northern, North-Western, and Luapula) and where MAZ works with them. They have also supported training in adolescent health in Nort Western Province, where there is a high incidence of teen pregnancies. UNFPA also supported the development of the midwifery curriculum; MAZ sits on the platform with support from UNFPA. When midwifery tutors have their annual meetings, midwives are supported to sit in those meetings to align the curriculum through UNFPA. | <p>Interview, national NGO staff. Lusaka, Zambia. August 2021.</p> |

Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support

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| <ul style="list-style-type: none"> ● “UNFPA has strengthened our organization – supported the strategic plan; supported us with constitution, etc. IDM and Scientific conference. Guidelines – printed etc. and launched by MoH.” ● UNFPA has assisted MAZ to mobilize resources; however, the strategic plan does not have a sustainability plan. Mentorship happens from the national level; however, the interviewee noted that strengthening mentorship capacity at provincial level would create a larger pool of mentors. ● It was noted that advocacy for a Chief Midwifery Officer, responsible for working with MAZ directly, would help strengthen MAZ position to influence policy and amplify the voices of midwives in the process. Without UNFPA support, MAZ would not have participated in the curriculum review conducted by the Nursing and Midwifery Council. | |
| <ul style="list-style-type: none"> ● They have also created long-term systems on some of the programmes. For example, UNFPA identified that the training of the midwives is very key in the improvement of maternal health and are working with the Midwifery Association of Zambia and General Nursing Council to ensure that there is an up-to-date curriculum for the training of the midwives. UNFPA ensured that fistula is incorporated in the training curriculum for nurses and what that means is that the nurse will graduate from the nursing school and will know about fistula. “UNFPA are looking at the broader picture.” ● “I know there are also other organizations working on midwifery, but I think UNFPA is the major organization that also worked on the curriculum. This allows the programme to continue even when there is no longer support from them.” | <p>Interview, MoH service provider. Lusaka, Zambia. August 2021.</p> |
| <p>Online survey</p> | |
| <p>Question 6: Extent of agreement with UNFPA contributions/results in midwifery</p> | |
| <ul style="list-style-type: none"> ● Most survey respondents (85 per cent) agreed/ strongly agreed with the following statements (slightly less than respondents to questions about pre- and in-service education) <ul style="list-style-type: none"> ○ UNFPA has strengthened the capacity of midwifery organisations to support the professionalization and capacity building of midwives. ○ As a result of UNFPA efforts, midwifery is today recognized (nationally & globally) as being one of the essential pathways to address MNH and reduce maternal and newborn deaths and disabilities. | |

Area of Investigation 2: Emergency obstetric and newborn care

Evaluation Question 2: To what extent has the MHTF supported ministries of health to design, strengthen and scale-up a national network of basic level and referral maternity facilities staffed with skilled health personnel and capable of providing quality sexual and reproductive health services as well as maternal and newborn care, including EmONC?

Sub-Questions:

- a) How and to what extent does the MHTF contribute to the development of nationally aligned strategies and policies to define and monitor the national network of EmONC facilities and strengthen referral linkages?
- b) To what extent has the MHTF contributed to the strengthened functioning of the national network of EmONC facilities to provide equitable, accountable, and quality SRHR services including through quality improvement (QI) and monitoring processes?
- c) To what extent does the MHTF contribute to strengthened capacities of skilled health personnel in EmONC facilities to provide equitable, accountable, and quality SRHR services?

| Evaluation criteria | <i>Relevance, effectiveness, efficiency, sustainability</i> |
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| Rationale | Women and newborns are at high risk of death and morbidity during labour, childbirth and the first week after birth. UNFPA activities to promote evidence-based policies and plans in support of increased access to equitable, accountable, and quality EmONC services aim to reduce maternal and newborn mortality and morbidity. UNFPA is building on lessons from previous MHTF phases to support planning and monitoring of the national network of EmONC facilities, strengthened QI processes, scale-up in additional countries, and to strengthen integration via further support to post-partum and post-abortion family planning and cervical cancer prevention. |

Assumption 2.1: MHTF efforts at global, regional, and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC

Indicators:

- Alignment between global and regional evidence-based guidance and national strategies for defining, monitoring, and scaling- up of strengthened EmONC and SRHR services
- Examples of MHTF advocacy and policy dialogue and partner coordination in support of national plans designed to strengthen and scale-up quality SRHR and MNH, including EmONC services within a well-defined network of facilities
- Trends over time in proportion of population covered by a functioning EmONC network of facilities (within two hours travel time)
- MHTF workplans include application of lessons learned (knowledge management) from prior phases to improve quality and support scale-up of services within countries and to new countries
- Views and experience of health authorities and partner institutions at global, national, and sub-national level regarding relevance, effectiveness, and synergy between other UNFPA interventions and MHTF efforts to address EmONC and support integrated SRHR and MNH services
- Views and experience of health authorities and partner institutions regarding UNFPA leadership on core principles of equity in access, quality of care, accountability, and on principles related to human rights and gender equality.

| Observations | Sources of evidence |
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| Global | |

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| <p>Assumption 2.1: MHTF efforts at global, regional, and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC</p> | |
| <ul style="list-style-type: none"> • University of Geneva (UNIGE) has been actively collaborating with UNFPA since 2015, bringing expertise in GIS/AccessMod (geographic access to health care) and in how to adequately teach and enable capacities in countries to effectively use them for EmONC network planning. More specifically with UNFPA SRHB/HQ in New York, UNIGE jointly engaged with the team in several missions together with West and Central Africa regional office (WCARO), and COs in Benin, Chad, Cote d'Ivoire, Guinea-Conakry, Burundi, Senegal, Togo, Sudan, Madagascar and Republic of Congo. | <p>University of Geneva, Concept Note, University of Geneva, Geneva, Switzerland, 2021</p> |
| <p>Working definition of a network of care for maternal and perinatal health</p> <p>A network of care for maternal and perinatal health optimizes linkages and the deliberate coordination and governance of service delivery to provide comprehensive, respectful, people-centred maternal and perinatal care from home/ community to referral levels. Key elements of networks of care for maternal and perinatal health:</p> <ul style="list-style-type: none"> • Addresses relational and functional aspects of the respectful provision of quality care and ensuring continuity of care and a positive experience for women and newborns • Includes formal and informal connections, collaboration and reporting between and across levels, including primary and specialty care • Is based on respectful teamwork and communication between all healthcare providers at different levels • Engages with transport, communication (mobile, radio etc.) and other sectors that support care • Provides mechanisms for joint accountability by health workers and with individuals and communities and for responding to evolving care needs and challenges (such as health crises) • Promotes equitable access to care, including reducing financial barriers • Measures and monitors health processes and outcomes for women and newborns; key principles guiding networks of care for maternal and perinatal health <p>Networks of care:</p> <ul style="list-style-type: none"> • are not new or parallel systems but build on what already exists • optimize the delivery of evidence-based packages of interventions • should aim for sustainable, national coverage though individual networks are likely to be sub-national yet scalable • can include both public and private service delivery sites and providers • should delineate operational relationships between partners and sectors, including around financial incentives • supports linkages with women and families including self-care, digital technologies, and telemedicine. | <p>Radovich, E, Mapping the landscape of networks of care in maternal and perinatal health: a working definition and way forward, Networks of Care Deliverable. New York. 2020</p> |
| <ul style="list-style-type: none"> • The objective of this approach is to support countries to improve the coverage of the population accessing EmONC gradually and realistically and to improve the quality of obstetric and newborn care. This approach was implemented with the support of the MHTF in Haiti in 2010 and subsequently in Togo and Madagascar in 2014-16. In 2017-19, other countries, such as Burundi, Benin, Chad, Guinea, Senegal, and Sudan also implemented it. These countries have addressed many problems related to developing a national network of EmONC facilities and have explored many avenues to improve access to quality EmONC, failed, started again and eventually succeeded. | <p>UNFPA, Implementation Manual for Developing a National Network of Maternity Units, 2020</p> |

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- The MoH selected a limited number of EmONC health facilities for its first national EmONC network, as very few EmONC facilities are currently functional. Monitoring the national network of EmONC health facilities in Benin, Burundi, Guinea, and Togo. In 2019, four countries monitored key reproductive MNH indicators in their national network of EmONC health facilities, including EmONC indicators: Benin, Burundi, Guinea, and Togo.
- The **indicators are defined by national and subnational stakeholders and validated by the MoH**. Data on the indicators are collected on a quarterly basis in all designated EmONC health facilities. Data collection is performed by “implementation support” teams, including members from regional and district health teams that assist health facility staff to analyse data and identify specific responses to improve the availability and quality of EmONC services. Similarly, district, regional and national teams analyse consolidated EmONC data and define responses to address gaps at their levels. This bottom-up approach is a paradigm shift in most countries that has defined a national EmONC network.
- **Only Togo, however, has currently reached the stage of analysing data and defining responses to improve the quality of care...**while the share of the population able to access a nearby EmONC health facility is high in Benin and Togo (94 per cent within one hour of travel time in Benin and 80 per cent within one hour in Togo), **the proportion of expected births taking place in EmONC health facilities is still very low in the two countries**. This reflects issues linked to financial access and quality of care.

The MHTF UNFPA, Annual Report 2019, UNFPA, New York, 2020

Emergency Obstetric and Newborn Care 2019 highlights

- The MHTF in 2019 continued to support the **establishment of physically accessible EmONC facility networks** and the provision of quality care.
- Twelve countries **improved the proportion of EmONC facilities with “no gaps” in midwives** according to the national standard. Burkina Faso now has “no gaps” in over 80 per cent of facilities. Twelve countries have EmONC facilities with quality improvement processes in place.
- In Benin and Guinea, over 50 per cent of the population are now able to reach EmONC facilities within two hours of travel time. In 2019, Benin and Burundi had at least 40 per cent functioning referral links between basic and comprehensive EmONC health facilities within the national network.
- Monitoring emergency obstetric care: A handbook: Setting up national networks of EmONC health facilities in Benin, Chad, Côte d’Ivoire and Sudan.
- In 2019, four more countries decided to review their EmONC development strategy. Health ministries in Benin, Côte d’Ivoire, Chad and Sudan requested for MHTF technical expertise and financial support to develop their national networks of EmONC health facilities. With the support of UNFPAs COs, various health ministry stakeholders, and with the GIS expertise of Geneva University, experts from each region of each country designed networks of designated EmONC health facilities. Following the usual process implemented in previous years in Burundi, Guinea, Madagascar, Senegal and Togo, and using the GIS/AccessMod tool, participants in each subnational region-built networks taking into account the population covered within two hours of travel time.

The MHTF UNFPA, Annual Report 2019, New York, 2020

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| <ul style="list-style-type: none"> • The main issue is not coverage, but quality of care and financial barriers... Another challenge faced while making EmONC networks functional is the limited competencies among obstetric service health providers, including midwives. This jeopardizes MNH health outcomes, a situation documented in Benin, Madagascar and Sudan. Skills are lacking due to poor curricula and teaching programmes. Given the needs in EmONC facilities, midwives should be able to manage all deliveries, and also have decision-making power to decide where and to whom to refer. Unfortunately, these decision-making powers are missing. EmONC facilities remain weak, with important competency gaps and shortfalls in quality of care. | <p>The MHTF UNFPA, Annual Report 2019, New York, 2020</p> |
| <ul style="list-style-type: none"> • By leading the technical agenda on EmONC development, the MHTF contributes to aligning efforts on EmONC by different partners, including the Muskoka funds, the H6 partners (WHO, UNAIDS UNFPA, UNICEF, UN Women, World Bank) and the Global Financing Facility (GFF). | <p>The MHTF UNFPA, Annual Report 2018, New York, 2019</p> |
| <p>Partnerships for EmONC Network development</p> <ul style="list-style-type: none"> • UNFPA, notably through its MHTF, has helped several countries to develop their EmONC networks. An innovative methodology has been put in place in the last five years and used in ten countries (Benin, Chad, Cote d'Ivoire, Guinea-Conakry, Burundi, Senegal, Togo, Sudan, Madagascar, Rep. of Congo). • This methodology has recently been published in a new UNFPA guidance document "Implementation manual for developing a national network of maternity units - Improving EmONC", published in September 2020, with UNIGE contributing to it. • In Sudan, UNIGE has also promoted GIS/AccessMod to UNFPA technical staff and has participated in the development of a UNFPA internal brief on "Designing an Integrated, Global Population Data Platform for UNFPA" targeting the UNFPA Population and Development branch, as well as a key multimedia product shown as a movie during the Nairobi Summit on International Conference on Population and Development 25 last year. | <p>University of Geneva, Workplan 2021: Concept Note, Geneva, 2020</p> |
| <ul style="list-style-type: none"> • EmONC network site mapping from a technical perspective has been done very well. But partners have moved on to the more comprehensive and holistic approach framed by the idea of Networks of Care, which take a broader view to include the quality of care offered, respectful care for the patient. In addition, the network of care model includes consideration of all care providers and their relationships with each other, especially at the community level. The community level as a driver of delays/ decision-making and the relationships with the community and health services is neglected or completely excluded in the EmONC network approach. | <p>Interview, multilateral partner, September 2021</p> |
| <ul style="list-style-type: none"> • A shift to networks of care, to consider communities and the first delay, quality of care etc. is vital to improving maternal health outcomes. The Pink Book [the agreed service level and standards of EmONC care] is currently being revised to incorporate community links, first delays etc. and we are not convinced that UNFPA will expand their approach in line with this. • Right now, the EmONC approach used by UNFPA is focused on a supply side method that follows a clear and explicit methodology. It is working well to some extent in ten or so countries despite limitations. | <p>Interview, global technical partner, September 2021</p> |
| <ul style="list-style-type: none"> • There is a methodological issue that also needs resolving: the World Bank has a similar but different methodology, and we need to get a joined agreement about which prioritisation approach is best to focus on. We think it should be the UNFPA model, which is much better in many ways. | <p>Interview global technical partner, September 2021</p> |

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| <ul style="list-style-type: none"> Also new targets/ standards being developed globally (UNFPA is co-chairing the Ending Preventable Maternal Mortality Initiative (EPMM) process that is overseeing this) and the programme will need to be adapted to reflect these in due course. | |
| <ul style="list-style-type: none"> The EmONC network approach is an innovation in two ways. It helps identify selected facilities to target resources. The process supports a country to look at what it has, and then use the Pink Book³ and the GIS mapping tool to develop a process of prioritising which facilities to invest in to create a functioning EmONC network that works together at two levels (first level of service and referral for complications). So, the innovation is to map out what you have and to decide what is worth investing in. The second innovation is to then monitor these facilities – once selected – to try to improve them. This monitoring is crucial, but UNFPA cannot do it alone. | Interview, global technical partner, September 2021 |
| <ul style="list-style-type: none"> At the country level, UNFPA needs to create and – most importantly - sustain policy focus and commitment to support monitoring of EmONC and upgrading facilities, improving standards of care. So far, there is not enough on respectful care. There is not enough attention on implementation, especially for quality. We have been talking about implementation for quality of care for years. In fact, we did some implementation work with UNFPA very successfully some years ago, but funding stopped. | Interview, global technical partner, September 2021 |
| <ul style="list-style-type: none"> Noted that there seems to be resistance from UNFPA to expand the EmONC network approach to community level. Evidence of what works is needed. It looks good but is it leading to fewer deaths? Supply of facility-based services only helpful if you don't have a situation where most babies are delivered at home. | Interview, global technical/ multilateral partner. October 2021 |
| Regional | |
| <ul style="list-style-type: none"> No observations | |
| Bangladesh | |
| EmONC System: | |
| <ul style="list-style-type: none"> Support to pre-service and in-service EmONC training for midwives, including didactic, simulation and clinical practice Technical support to put in place required health systems components for the implementation of 24/7 response to obstetric and newborn emergencies Advocacy for post-partum haemorrhage and eclampsia action plan implementation and supervision Training and mentoring of midwifery faculty including link with obstetrics and gynaecology (OB/GYN) professional organizations for mentoring and advocacy. | UNFPA, Ending Preventable Maternal Mortality: Country Review and Roadmap for action, 2020, p. 4 |
| <ul style="list-style-type: none"> We have completed planning and organization of this mentorship programme to be implemented in other districts using MHTF funds in third and fourth quarter of 2018. We have just received another award that will allow us to expand the focus on ensuring rural facilities are ready to provide emergency care. The MoHFW EmONC core committee has been meeting quarterly with coordination support from UNFPA. | UNFPA, 2018 Midyear Progress Report, 2019, p. 7 |

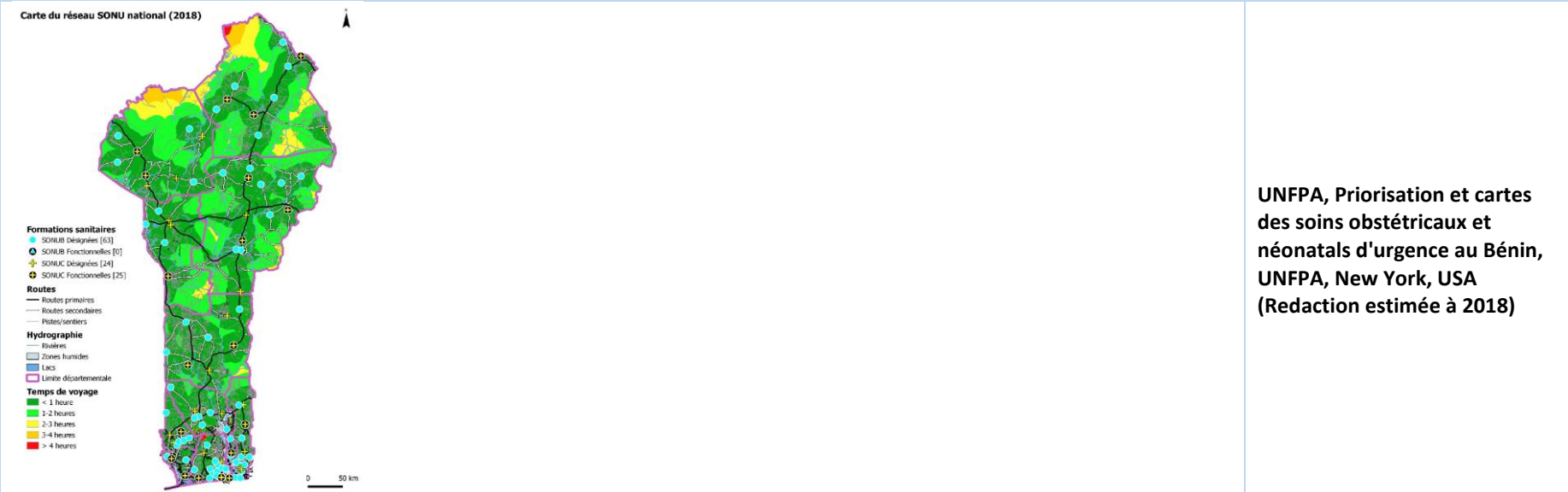
³ The Pink Book refers to “Monitoring Emergency Obstetric Care: A Handbook” published in 2009 by WHO, UNFPA, UNICEF and AMDD. The Pink Book is currently being updated and will include a community lens/ component and other components like stillbirth.

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| <ul style="list-style-type: none"> ● A National postpartum haemorrhage (PPH) and Eclampsia Action Plan has been developed through a technical working group, several stakeholders' meetings were organized, and the plan was endorsed by MoHFW. The dissemination of the action plan has started and will continue throughout the rest of the year. Ten separate district meetings have been organized with district and sub-district level authorities to orient them on application and orientation of the PPH and Eclampsia Action Plan. ● UNFPA organized two trainings for 53 warehouse managers from the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP). This training focused on stock management and avoiding stock outs of medicines and medical supplies. The trainings have been followed up with regular phone calls and follow up to remedy low stock situations. Many problems have been identified with this follow up process and information about the issues are being fed back to the local and national authorities for more systematic solutions. ● Workshops to establish EmONC networks and referral pathways have been organized. During these workshops, local health managers and health care providers from 18 districts have identified all strategic basic emergency obstetric and neonatal care (BEmONC) and comprehensive emergency obstetrics and newborn care (CEmONC) facilities, and drafted network plans and referral pathways. The plans have been approved by local DGFP and DGHS authorities. The next step will be to capacitate government stakeholders to mobilize resources for functionalizing these networks. | |
| <ul style="list-style-type: none"> ● UNFPA had done excellent work previously in providing training on EMONC to doctors and nurses. This training needs to be introduced for midwives as refresher/in-service training. At national level, UNFPA is member of EOC core committee and participates actively in setting up policy directions. Partners in EmONC: Save the Children, UNICEF, WHO, PLAN, Government of Bangladesh, Midwifery institutes and others. | <p>National Professional Officer, WHO, Dhaka, Bangladesh, June 2021</p> |
| <ul style="list-style-type: none"> ● In 2019, UNFPA Midwifery and EmONC programme made significant progress in achieving CP9 intended results. To accelerate the reduction of maternal mortality and morbidity and to ensure the availability of 24/7 EmONC services, the MoHFW with technical/ financial support from UNFPA developed and disseminated a National Strategy for Maternal Health 2019-30 with SOPs to support implementation. ● UNFPA also supported the government to ensure the availability of life-saving drugs in all health facilities. As a result of ongoing efforts, 98 per cent of Upazila health complexes reported to have been able to provide EmONC services without any stock-outs of life-saving drugs (in the last six months). According to the UNFPA periodic monitoring data, 155 union health facilities in targeted districts provided 24/7 basic EmONC services in the target districts in 2019 with following results: <ul style="list-style-type: none"> ● 49 districts have established network of facilities providing 24/7 EmONC services ● 861 women in tea gardens were referred to EmONC facilities ● 32 Upazila health complexes provided 4 out of 7 EmONC signal functions ● 98 per cent of upazila health complexes provided EmONC services without stock-outs of life-saving drugs ● Additionally, through UNFPA support, 31 midwives' capacity was strengthened to deliver EmONC in humanitarian settings. | <p>UNFPA, 2019 Annual Report MHTF Bangladesh, 2020, p.3</p> |

Benin

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UNFPA, Priorisation et cartes des soins obstétricaux et néonataux d'urgence au Bénin, UNFPA, New York, USA (Redaction estimée à 2018)

Le MHTF a effectué un plaidoyer politique, facilité un dialogue national et apporté un soutien technique à la mise en place d'un réseau national SONU. Le processus a commencé en 2016, et l'institutionnalisation, qui s'est déroulée en 2017 et 2018, a culminé avec la rédaction du **Rapport Technique en 2019 (publié en 2020).**

Les différentes étapes sont :

- 1) **Evaluation rapide des besoins en Soins Obstétricaux et Néonataux d'Urgence (SONU) en 2016**, qui a permis d'identifier que seuls 26% des besoins en SONU étaient satisfaits, et une létalité de 4.8% au niveau des **Formations Sanitaires SONU, posant le problème de la qualité de l'offre de soins.** Sur la base des résultats de l'évaluation, le Ministère de la Santé a initié les premières étapes du processus de construction du réseau national de maternités SONU. **Une mission d'assistance Technique de haut niveau** venant à la fois du Bureau du Togo, de l'UNFPA TD et du Bureau régional de Dakar a été obtenue pour discuter des étapes qu'implique la mise en place d'un réseau national des formations sanitaires SONU en collaboration avec un expert en GIS/AccessMod de l'Université de Genève.
- 2) **Etapes de la mise en œuvre du réseau SONU en plusieurs étapes :**
 - a. **Consolidation de la décision politique** de reconstruction du réseau national des SONU (oct 2017)
 - b. **Formation d'un pool d'experts sur le Système d'information Géographique (SIG)** (Nov 2017)
 - c. **Vision consensuelle** du développement du réseau national des maternités SONU (Mai 2018)
 - d. **Trois ateliers de priorisation** des formations sanitaires offrant les SONU (Nov-Dec 2018).

Termes de référence de la mission d'appui à la validation du rapport technique de priorisation des SONU au Bénin

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| <p>e. Validation du rapport technique de priorisation des SONU en vue de disposer d'un document national des SONU qui servira de cadre de référence pour tous les intervenants dans ce domaine.</p> <p>f. Développement d'un outil simplifié pour le monitoring des formations sanitaires SONU a été également élaboré sur la base des indicateurs traceurs de SONU.</p> <p>g. Réalisation d'un costing des formations sanitaires SONUB comme outil de plaidoyer pour la mobilisation des ressources financières – financé par la Banque Mondiale</p> <p>Le processus a impliqué une large variété d'acteurs aux niveaux national et international --Médecins de zones, partenaires techniques et financiers (PTFs), Ministère de la sante, mais aussi internationaux (Université de Genève, UNFPA (Siège et Bureau du Togo) -- et est fondé sur des bonnes pratiques existantes.</p> | <p>UNFPA, Rapport Annuel, 2018</p> |
| <ul style="list-style-type: none"> ● La stratégie de priorisation des formations sanitaires SONU et a permis de retenir un réseau de 112 formations sanitaires SONU dont 66 SONUB en 2018. Ce réseau de 112 maternités SONU était en mesure de couvrir 97% de la population (à une heure de trajet) - une performance supérieure à l'ancien réseau composé de 125 maternités et couvrant 93% de la population. Il était alors estimé qu'il serait possible de réduire ce réseau à 108. ● 111 sur 112 formations sanitaires disposent des normes en matière de ratio population/SONU (5 SONU pour 500.000 habitants). | <p>UNFPA Rapport Annuel, 2018</p> |
| <ul style="list-style-type: none"> ● En 2019, le réseau a été réduit à 109 formations sanitaires SONU qui couvrent 77% de la population, dont 30 ont une qualité suffisante et ● Une fois que des SONU ont été priorisés avec médecins de zones de santé, les équipements sont concentrés sur les centres d'excellence | <p>Entretien, UNFPA bureau pays, Mai 2021, Benin</p> |
| <ul style="list-style-type: none"> ● Les critères qui aident à la priorisation des formations sanitaires SONU sont principalement : (i) la densité de la population (bassin de population) ; (ii) le nombre d'accouchements ; (iii) les liens entre SONUB et son SONUC et (iv) la couverture de la population. Le nombre de personnel qualifié, le déficit en fonctions signalétiques, la qualité du management de la formation sanitaire et la compatibilité de la structure avec un SONU sont aussi à considérer. ● Les sage-femmes sont indispensables pour les SONUB. La norme retenue au Bénin est quatre (4) sage-femmes pour une formation sanitaire SONUB. ● Le monitoring des formations sanitaires SONU doit tenir compte au moins des trois indicateurs ci-après : les besoins en sage-femmes, le nombre de formations sanitaires SONU fonctionnels et le lien entre les SONUB et les SONUC. ● Le renforcement des compétences des sage-femmes pour la prise en charge des SONUB se réalise à travers : <ul style="list-style-type: none"> ○ L'amélioration de la formation initiale axée sur les soins respectueux, les accouchements sûrs et les SONUB ○ L'accréditation des lieux de stage (clinique et pédagogique) ● Le déploiement des sage-femmes compétentes en priorité dans les SONUB. | <p>Atelier n° 3 de priorisation des Formations Sanitaires SONU pour les départements de : l'Alibori, l'Atacora, Borgou et de la Donga.</p> |
| <p>Au-delà de ce soutien technique qui a permis la définition de cette stratégie, le MHTF appuie directement un certain nombre de formations sanitaires SONU (49 via le Takeda Fund ainsi que 24 dans les zones de santé de Zou et Collines) ; « on a donné idées mais on ne peut pas tout couvrir »</p> | <p>Entretien, UNFPA bureau pays, Mai 2021, Benin</p> |

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| <p>Autres PTFs impliqués</p> <ul style="list-style-type: none"> ● Enabel (Coopération Belge) – renforcement de la fonctionnalité de centres SONU et construction de maternités (dans deux ZS Atlantique, Cofou, Collines) à travers deux programmes (P@sris (Programme d’@ppui à la santé sexuelle et reproductive et à l’information sanitaire), financé par AFD (13 millions euros) et Equité (Ensemble pour une qualité des soins inclusive et transparente, orientée vers l’égalité genre))- et Banque Mondiale (réalisation d’une étude pour évaluer les coûts et soutien direct à des formations sanitaires). ● MHTF ne construit pas de maternité, mais ENABEL le fait. Il y a une bonne complémentarité, car quand les ventouses ne sont plus fonctionnelles par exemple, UNFPA | <p>Entretien, UNFPA bureau pays, Juin 2021, Benin, Seydou</p> |
| <p>Challenges :</p> <ul style="list-style-type: none"> ● Le maintien des fonctions SONU dans les 112 formations sanitaires. ● Le maintien des sages-femmes au poste. ● Le respect des normes en effectif des sages-femmes par formation sanitaire (4) | <p>UNFPA Rapport 2018</p> |
| <p>The tool has become routine now. Before it was too large and difficult to use.</p> | <p>Interview with UNFPA staff, Benin, 25 June 2021</p> |
| <p>MHTF a été précurseur</p> <ul style="list-style-type: none"> ● UNFPA a été très visible sur la question des SONU. Je crois que c’était la première fois que nous avons connu un programme d’envergure nationale avec toutes les composantes, notamment la programmation au plus haut niveau, la formation des acteurs sur le terrain, la mise à disposition d’équipements et d’intrants etc. Comme le programme a eu du succès dans la phase précédente du MHTF, UNFPA a naturellement continué dans la troisième phase. | <p>Agence multilatérale, Juillet 2021, Benin</p> |
| <p>Positionnement catalytique Le MHTF ne couvre pas 34 zones mais utilise le monitoring pour faire du plaidoyer auprès d’autres PTFs pour augmenter le nombre de centres SONU fonctionnels ; besoins de ressources additionnelles (projet en cours d’élaboration avec la Banque Mondiale et Fonds Takeda)</p> | <p>Entretien, UNFPA bureau pays, Mai 2021, Benin</p> |
| <p>Sudan</p> | |
| <p>EmONC need and utilization identified (evidence base established)</p> <ul style="list-style-type: none"> ● There is a 68 per cent gap in EmONC availability in Sudan. Only 127 out of 396 recommended facilities provide basic and comprehensive EmONC. ● The biggest gap is in basic EmONC (BEmONC) availability (95 per cent). Only 15 facilities are classified as BEmONC out of the 317 recommended. However, one-third (204) of the facilities included in the assessment were, “Almost there” partially functioning EmONC sites (only missing one or two signal functions). Rural facilities accounted for the majority of “Almost there” facilities (66 per cent). ● The gap in EmONC availability was severely inequitable across states, ranging from 9 per cent of the recommended number of EmONC facilities in East Darfur to 98 percent of the recommended number in River Nile. | <p>MoH, Mapping and Assessment of Maternal, Neonatal and Child Health Emergencies and Rehabilitation Services 2017, MoH, Khartoum, Sudan, 2018</p> |

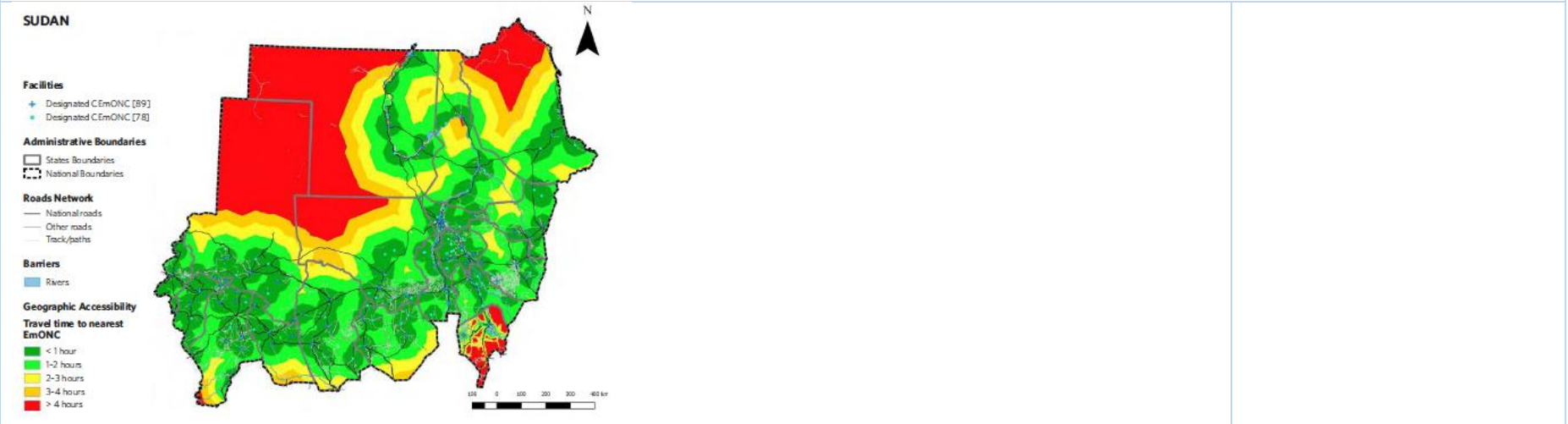
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| <ul style="list-style-type: none"> ● The proportion of expected births that took place in health facilities was only 23 percent. When looking at EmONC facilities only, this proportion drops down to 13 percent of expected deliveries. ● Met need for obstetric complications was very low (3 per cent in EmONC facilities), while caesarean delivery rate as a proportion of expected births was within the UN recommended range (8 per cent in all facilities and 5 per cent in EmONC facilities). ● Nationally, 545 maternal deaths were recorded in the facilities assessed (this did not include maternal deaths at lower facilities or those that happened in the community). ● The most common direct causes of maternal death were consistent with other country reports: PPH/retained placenta (35 per cent of maternal deaths from a direct cause), severe pre-eclampsia and eclampsia (21 per cent), and postpartum sepsis (18 per cent). If antepartum haemorrhage is included, haemorrhage accounted for 43 per cent of maternal deaths due to a direct cause. | |
| <ul style="list-style-type: none"> ● Institutional deliveries are estimated at 25 per cent (EmONC needs assessment) and contraceptive prevalence rate is 13.5 per cent (MICS 2014). In 2018, the State has notified 46 maternal deaths (MDSR 2018). | <p>UNFPA, EmONC Prioritization - Technical Report: State Level Analysis, Khartoum, Sudan 2017-2018</p> |
| <p>Cause of maternal deaths</p> <ul style="list-style-type: none"> ● Home delivery, late presentation, unavailability of blood and poor referral system, poor implementation of management protocols, unavailability of functioning ICU or high dependency unit (HDU) are the main factors behind maternal death. ● Sepsis/pneumonia (28 per cent), birth asphyxia (28 per cent); and complications of preterm birth (35 per cent) are the factors driving newborn deaths. Many of these conditions are preventable and closely linked to the absence of skilled birth attendance at delivery. ● Originally, a total of 631 health facilities (17 Referral/specialized hospitals, 58 state/general hospitals, 365 locality/rural hospitals, 53 private or NGO maternity/general clinics and 138 public or NGO/private health centres) that had provided childbirth services at the time of the assessment were included. ● The UN guideline recommends a minimum of five EmONC facilities for every 500,000 population. Accordingly, 396 EmONC facilities were recommended to be functioning and only 127 were fully functioning as EmONC (32 per cent), leaving a gap of 275 EmONC facilities. | <p>MoH, Sudan Standards and Norms for Emergency Obstetric and Newborn Care, 2020, MoH, Khartoum, Sudan. p.12</p> |

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| <p>FMoH engagement and commitment</p> <ul style="list-style-type: none"> ● In 2017, the FMoH conducted EmONC assessment with almost total coverage to all health facilities in Sudan identifying the gaps to make strategic work plan network formation. It was “a very huge work”. ● Currently most of the cost is covered by the government with some contribution from UNFPA. However, UNFPA supported the task group to meet for the prioritization of health facilities and network formation (a major job that continued throughout 2017 and 2018) and supported the dissemination of the plans in 2018. ● Due to the country context and political instability at that time, the work stopped in 2019 during the revolution and was then re-endorsed in July 2020 by signing an agreement with UNFPA. Validation of the network is now being supported technically by an international consultant. | <p>Interview, RH Team, Federal MoH, Khartoum, Sudan, 1 June 2021</p> |
| <ul style="list-style-type: none"> ● Each BEmONC needs to link to a CEmONC within two hours travel: that is part of making a network. In Sudan, there are 89 links between CEmONC and BEmONC of which 54 per cent were green (active). ● From 2019, the FMoH prioritised the EmONC network. This decision came about because of low availability of functioning EmONC facilities discovered in the 2018 survey. | <p>Webinar presentation, FMoH, Khartoum, 17 June 2021</p> |
| <p>UNFPA investment in EmONC globally</p> <ul style="list-style-type: none"> ● Health ministries in Benin, Côte d’Ivoire, Chad, and Sudan requested for MHTF technical expertise and financial support to develop their national networks of EmONC health facilities. With the support of UNFPA COs, various health ministry stakeholders, and with the GIS expertise of Geneva University, experts from each region of each country designed networks of designated EmONC health facilities. | <p>UNFPA, MHTF Annual Report 2019, 2020, UNFPA, New York, USA</p> |
| <p>Specific Objectives of FMoH EmONC investments</p> <ul style="list-style-type: none"> ● Through the financial and technical support from partners (UNFPA, UNICEF, and others), the 2017 Sudan EmONC assessment was a national cross-sectional facility-based census of both public and private hospitals and all mid-level facilities (health centres and private clinics) that provided maternity services at the time of the assessment...the first in its kind for the country <p>FMoH outlined their objectives to provide:</p> <ul style="list-style-type: none"> ● Clear definition of national standards and norms that govern the EmONC services delivery ● Guidance to programme managers and policy makers to plan for EmONC services ● A field friendly, step by step guide to implement, improve and upgrade EmONC services in Sudan. | <p>MoH, Sudan Standards and Norms for Emergency Obstetric and Newborn Care, 2020, MoH, Khartoum, Sudan</p> |
| <p>EmONC Network development</p> <ul style="list-style-type: none"> ● Support of the CO to FMoH for the assessment of health facilities across the country to determine/identify a network of suitable facilities for the EmONC network. ● Should have 30 deliveries per month to be sufficiently active. ● Each State prioritised facilities to target for inclusion in the network. The process used the GIS approach. ● There was then a process of undertaking the needs assessment of these facilities in each state network across the country. | <p>Interview, RH Team, UNFPA CO Khartoum, 17 June 2021</p> |

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| <p>Low access in Blue Nile State</p> <ul style="list-style-type: none"> ● Overall geographic accessibility to EmONC health facilities in Sudan is good with most of the population able to access the closest facility within two hours. This is mostly due to very low population concentration in the red zone, which is mainly desert. ● An exception is the State of Blue Nile, where only 48 per cent of the population has access within two hours due to poor road networks and insecurity. Most functioning EmONC health facilities face major shortfalls in quality of care, however. ● Closer monitoring will help the SMOH to address these issues, including unnecessary surgical interventions such as caesarean sections. Through UNFPA support, the ministry will also strengthen its midwifery workforce and ensure more basic EmONC health facilities function and offer quality of care. | <p>UNFPA, MHTF Annual Report 2019, 2020, UNFPA, New York, USA</p> |
| <p>Evolution of the EmONC Network</p> <ul style="list-style-type: none"> ● Updated EmONC network based on recommendations by the senior technical team (FMoH, UNFPA HQ, and the university of Geneva) ● The GIS mapping finalized by the FMoH in 2019 ● Khartoum state network validated in 2019; an additional five states (Sinnar, White Nile, North Kordofan, Gedaref and River Nile States) are expected to finalize the prioritization before the end of 2020 ● EmONC standards and norms and service quality improvement package were developed in 2019 ● Established the National EmONC support team to provide technical assistance including to the states. | <p>UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>EmONC Network policy and evidence</p> <ul style="list-style-type: none"> ● A plan was made by UNFPA and the FMoH to do an assessment of the network. ● The results were good, and more partners have been increasingly engaged in this programme including the African Development Bank. ● Despite challenges like the revolution, COVID-19 and the floods, the EmONC network continues to exist, “We are still working on the network.” ● Under process: technical issues and reassessing needs of selected health facilities. “We are reassessing health centres for the network and to assess the gaps that need to be addressed most urgently.” | <p>Interview, (RH coordinator/ MCH director/UNFPA) Research/practitioner, Khartoum, Sudan, 15 June 2021</p> |
| <p>The EmONC Network mapping for Sudan</p> | <p>UNFPA, MHTF Annual Report 2019, 2020, UNFPA, New York, p.16</p> |

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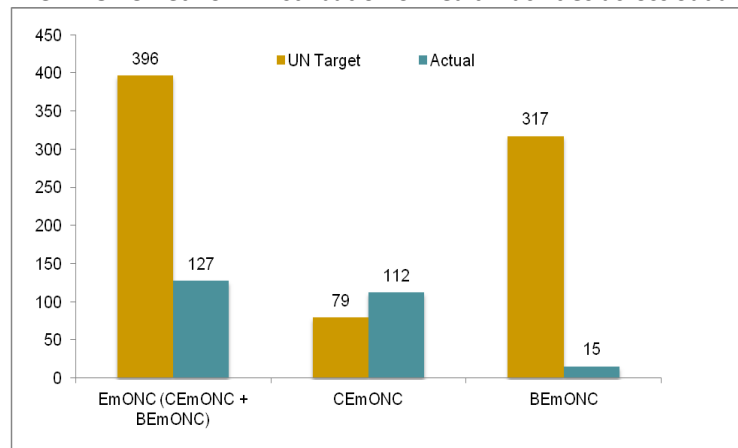
Continuing EmONC support

- The **EmONC networks development** and health facilities prioritization and dissemination
- **Development of core EmONC documents** (Standards& Norms and Quality improvement packages and the maps for EmONC facilities)
- **Training of GIS local (government) experts** on Access mode by Geneva University to facilitate the EmONC network development workshops
- **Establishment of EmONC support team** and conducting of first round monitoring

Review of programme activities, UNFPA CO, Sudan, 22 June 2021

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The EmONC Network: Distribution of health facilities across Sudan



MoH, Sudan Standards and Norms for EmONC, 2020, MoH, Khartoum, Sudan, p.11

Results of the process

- The State teams have designated 88 CEmONC and 79 BEmONC health facilities, for a total of 167 EmONC health facilities (below the 189 health facilities corresponding to half of the norm of 5 EmONC per 500,000 population). Among these health facilities, **there are only 55 EmONC health facilities providing the EmONC signal functions** - based on the EmONC Assessment of 2018 and further analysis by the State working groups. The States of Khartoum and El Gazira have the highest number of functioning health facilities. The **EmONC availability for the national EmONC network designated by the State Working Group is 33%** (55/167). In addition, none of the States have all the designated EmONC health facilities functioning. The first EmONC monitoring that is planned in 2021 will update the functionality of the designated EmONC health facilities.
- The low EmONC availability in Sudan highlights the importance of limiting the spread of scarce resources (including human resources such as midwives) to make these designated EmONC health facilities functioning 24h7d with quality of care. While the State teams have made an important prioritization effort, the support team suggests to slightly reducing the national designated EmONC network in Sudan from 167 designated EmONC health facilities to 158 EmONC health facilities (**with 114 designated CEmONC health facilities and 44 designated BEmONC health facilities**). Among the 158 EmONC health facilities proposed by the support team, 139 were proposed by the State working group and among these, 21 health facilities are proposed by the support team as designated CEmONC instead of designated BEmONC health facilities ... The **EmONC availability for the national designated EmONC network proposed by the Support Team is 40%** (63/158).
- In Sudan, all the 690 maternities cover 96% of the population within 2h travel time. The 167 EmONC health facilities designated by the State working group cover 92% of the population. Among these designated health facilities, **the 55**

Identifying the national network of health facilities providing Emergency Obstetric and Newborn Care (EmONC) in the Republic of Sudan, Technical Report, UNFPA in collaboration with the University of Geneva, August 2021. P.22-24

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| <p>functioning EmONC health facilities selected for the EmONC network by the State working group cover 74% of the population. These results confirm the importance of focusing the scarce resources available on this limited number of EmONC health facilities to make them function as it is possible to cover with 167 EmONC health facilities a similar proportion of the population than with all the maternities of the country.</p> | |
| <p>Togo</p> | |
| <ul style="list-style-type: none"> ● L'UNFPA a été la pionnière de la stratégie SONU au Togo avec au départ la cartographie des besoins en SONU, réalisée entre 2012 et 2013 ayant conduit le pays à identifier des structures sanitaires pouvant potentiellement offrir les SONU. Cette cartographie a permis de recenser une centaine de formations sanitaires qui étaient censées offrir des SONU. L'UNFPA a accompagné la mise en place de tout le dispositif en termes de ressources humaine (plaidoyer pour le déploiement des sages-femmes), les équipements adaptés pour l'offre des SONU (ventouses, kits pour l'aspiration manuelle intra utérine, les produits de la santé de la reproduction d'urgence, (sulfate de magnésium) ont été également mis en place. ● Il y a eu ensuite le renforcement des prestataires à l'utilisation de ces équipements. Une série de formation a eu lieu en 2015 et 2016 si bien que dans chaque structure SONU, il y a au moins un prestataire qui peut offrir les soins. Le volet SONU est soutenu par l'UNFPA au Togo avec un suivi périodique de façon semestrielle. Grâce au soutien de l'UNFPA. ● En 2019, il y a eu la révision de la cartographie qui a permis de passer de 109 à actuellement 73 structures opérationnelles pour l'offre des SONU. ● Cette cartographie de 2019 est celle qui est actuellement appliquée. L'UNFPA a rendu disponible, toute une gamme de matériels médico-techniques et d'équipements dont a bénéficié les formations sanitaires SONU et non SONU. De façon annuelle, il y a un équipement qui est mis à disposition des formations sanitaires selon les besoins. L'UNFPA continue d'appuyer les structures sanitaires en dotations des équipements et a maximisé les ressources pour rendre certaines structures SONU fonctionnels. Chaque semestre, il y a le monitoring qui permet d'évaluer la disponibilité et l'utilisation des fonctions SONU pour pouvoir apprécier la fonctionnalité des structures. En 2019 il y a eu également une formation des prestataires en SONU, financée par l'UNFPA. | <p>Interview, MoH staff, Togo, June 2021</p> |
| <ul style="list-style-type: none"> ● Les interventions de l'UNFPA ont permis d'améliorer le nombre de SONU fonctionnels, le nombre de femmes qui sont planifiées chaque année qui a connu un progrès du fait de la diversification des stratégies. La distribution à base communautaire est une stratégie très porteuse qu'il faut mettre à échelle. | <p>Interview, UNICEF staff, Togo, June 2021</p> |
| <ul style="list-style-type: none"> ● Au niveau des agences des Nations-Unies, le plaidoyer c'est un de nos domaines prioritaires d'action. Donc l'UNFPA continue de faire ses plaidoyers pour les ressources humaines tout comme pour la mobilisation des ressources. Il y a des initiatives que le gouvernement a prises dans le pays grâce au plaidoyer de l'UNFPA. Par exemple, la décision de la gratuité de la césarienne il y a quelques années, c'est pour donner suite à la campagne CARMMA que l'UNFPA avait faite. Des avancées au plan des SONU 2012-2013 : Evaluation des SONU ayant débouché sur un plan de renforcement Cartographie révisée entre 2018 et 2019 Renforcement des capacités du personnel de santé Dotation des structures en équipements Actions visant à améliorer la qualité des accouchements Mise en œuvre d'une politique de délégation des tâches aux sages-femmes pour ce qui concerne la | <p>Interview, UNICEF staff, UNICEF, Togo, June 2021</p> |

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| <p>réalisation de l'échographie Achat d'échographes pour des formations sanitaires de niveau secondaire Renforcement des sages-femmes à l'utilisation Ces interventions ont induit l'amélioration du suivi des grossesses.</p> | |
| <ul style="list-style-type: none"> UNICEF ; OMS ; USAID et autres partenaires appropriés Autres partenaires engagés dans les SONU : AFD (projet MUSKOKA dans la région maritime) Projet KFW santé, droits sexuelle et droits reproductifs mis en œuvre dans la région de la Kara GIZ. | Interview, MoH staff, Togo, June 2021 |
| <ul style="list-style-type: none"> Disons que sur le plan de médicaments l'UNFPA met à notre disposition tous les produits SR. Les produits dont avons besoin pour prendre en charge les urgences dans les SONU par exemple l'ocytocine, le misoprostole, le sulfate de magnésium que nous utilisons pour les cas de prééclampsie. Nous avons tous ces médicaments à notre disposition et c'est gratuit (Dotation de médicaments SR et SONU gratuits). Ça fait que nous arrivons à prendre en charge facilement ces cas. En dehors de ça, nos formations sanitaires sont équipées. Les formations sanitaires SONU surtout son est équipées de matériels pour prendre en charge les urgences, c'est-à-dire que nous avons les KIT AMIU pour les cas d'avortement, nous avons des Kit de ventouses pour nous aider à extraire le nouveau-né rapidement chez les mamans qui sont dans le besoin, nous avons les Kits de réanimation du nouveau-né aussi dans quelques formations sanitaires. En plus les formations sanitaires de SONU, il y a une formation sanitaire qui a aussi l'échographe. C'est le CMS Agbélouve qui a l'échographe et en dehors de son échographe il y a aussi l'échographe au CHR. C'est de ces 2 échographes que le district se sert pour surveiller les femmes. Dans tout le district de zio il y a deux échographes : CHR et CMS Agbelouvé (équipements des formations sanitaires). Nous avons officiellement quatre SONU. Il y a le CMS Agbelouvé, Gapé centre, la polyclinique de Tsévié qui est l'hôpital de district, Gapé centre, polyclinique de Tsevié ou encoren l'hôpital de district de zio. C'est la même chose. Il y a Djagblé qui est associé ces derniers temps. En dehors de tous ces choses nous avons eu aussi à améliorer la capacité des prestataires, il y a eu des formations pour le renforcement des capacités des prestataires sur par exemple la planification familiale, SONU, une formation SONU qui englobe beaucoup de chose, il y a des formations sur la PF y compris DIUPP (Amélioration du plateau technique, renforcement des capacités du personnel). | Interview, District Health Officer, Government, Togo, June 2021 |
| <ul style="list-style-type: none"> La nouvelle cartographie des structures SONU du Togo a été validée par les acteurs nationaux. Le nombre de FS SONU pour tout le pays est désormais de 73 conformément à la norme de 5 FS SONU pour 500 000 habitants et à l'accessibilité géographique des centres. 24 sages-femmes formées sur les 7 fonctions essentielles SONU de base et 21 sur la pratique de l'échographie obstétricale. 50 sages-femmes formées en insertion DIUPP. Les capacités des équipes régionales pour la conduite du monitoring des SONU ont été renforcées avec une formation et leur encadrement pour la collecte et l'analyse de façon des résultats du monitoring. <p>Au niveau national, le monitoring a révélé en matière de :</p> <ul style="list-style-type: none"> Utilisation, une proportion de formations sanitaires de : 35% pour les SONU B soit (16 FS sur 46) - 71 % pour SONUC (19 sur 27) - 48% (35/73), pour l'ensemble des SONUB+C. Fonctionnalité (utilisation, ouverture 24H/24 et formations sanitaires disposant au moins 3 sages-femmes), une proportion de formations sanitaires de : 21,7 % pour les SONU B soit (10 FS sur 46) - 71% pour SONUC (19 sur 27) - 40% (29/73), pour l'ensemble des SONUB+C. | UNFPA, Template for MHTF Reporting, Togo, 2019 |

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| <ul style="list-style-type: none"> ● 28 prestataires des sites SONU et des enseignantes sages-femmes de deux écoles de sage-femme ont été formés sur la pratique de l'échographie obstétricale. ● 50 prestataires des sites SONU ont été renforcés en PFPP/DIUPP et PF en soins après avortement. | |
| <ul style="list-style-type: none"> ● Togo EmONC new mapping was conducted, leading the number of facilities from 109 to 67, in respect of the international standard. This EmONC mapping was supported by RH Advisor/UNFPA HQ, family planning and reproductive health specialist from WCARO and a mapping expert from the UNIGE. ● Technical report on the new regional EmONC networks that include regional level the geographical positioning of health facilities, the populations covered individually by each health facility and by the entire network, the situation of midwives and the gaps to be filled, natures reference links between BEmONC and CEmONC, and an analysis of the individual strengths and weaknesses of each health facility, to be focused during the capacity building, is being drafted. EmONC monitoring has been conducted, gathering data situation during the first semester 2018. ● Prior to this, the data collection tool has been revised and adapted to district health information system (DHIS) 2 data set; the monitoring indicators will be parameterized and integrated into the DHIS2 of the MoH, in order to lead regions appropriating the analysis of the data collected. | <p>UNFPA, 2018 Template for Country Annual Joint Reporting for the MHTF and Joint Programmes</p> |
| <ul style="list-style-type: none"> ● Support building an EmONC national model (missions, norms, organization modalities) as a reference for availability and quality of care assessment. ● The integrated maternal death surveillance and response (MDSR) / EmONC report elaborated in 2017, has been reinstated in April 2018 to the health authorities and partners with the support of the RH Adviser/UNFPA HQ. ● The follow-up of midwives trained on the use of obstetrical ultrasound in 2017 was conducted by the master trainers, through EmONC sites. ● Seventy health care providers from 70 EmONC facilities were trained to manage complications of childbirth, with "Help the Mother Survive" approach. This activity was mainly funded by MUSKOKA; MHTF was used to complete the funding. | <p>UNFPA, 2018 Template for Country Annual Joint Reporting for the MHTF and Joint Programmes</p> |
| <p>Uganda</p> | |
| <ul style="list-style-type: none"> ● "Regarding EmONC, while it did not look like we invested a lot in EMONC and upstream work, there was a lot of investment in the humanitarian response." ● "I want to clarify that on EMONC, of course in 2020, we include funds for EMONC in the (MHTF) work plan but was part of the money that was reprogrammed when we were responding to COVID-19. In 2021, we have some more funds to monitor/mentor EMONC, so there are some funds in the 2021 work plan. | <p>Group discussion, UNFPA Uganda staff, May 2021</p> |
| <ul style="list-style-type: none"> ● The EmONC network model promoted by MHTF is focused on accessibility modelling utilizing EmONC network process software developed in partnership with the University of Geneva. The effort includes building capacity in countries to use GIS software and working closely with MoHs to institutionalise it and work through the four phases of network development. ● UNFPA Uganda decided not to use the network approach for EmONC. | <p>Interview, global key informant, September 2021</p> |
| <ul style="list-style-type: none"> ● When asked if the CO received information or guidance on the EMONC "network" approach, the response was negative. | <p>Interview, UNFPA Uganda staff, Kampala, May 2021</p> |

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| <ul style="list-style-type: none"> ● “I do not remember when we last received funding for EmONC. We have received funding for the other 3 areas – it is only this year that we have received EmONC support again, but overall, EmONC has not received much funding.” ● “Of course, we are the ones who make the work plan – and when we look at the funding, we prioritise what is most important. We did put some activities on EmONC, but I cannot remember why the funding for EmONC did not come through. But also if we look at other areas as fistula, MPDSR and midwifery also contribute to EmONC. ● We also put some EmONC activities in the Sida proposal. ● One of the ANSWER programme IPs, Marie Stopes, did a rapid assessment of needs in the facilities – so they conducted a BEmONC training because it was found to be a great gap. They were addressing the demand side – but they needed to make sure that quality services were there. Also under the ANSWER programme, there is an element of coaching.” | |
| <ul style="list-style-type: none"> ● This model is an innovative approach to develop a national network of referral maternities accessible by the population and able to manage all obstetric and neonatal complications with quality of care. ● It supports the reorganization of the health system through the identification and selection of a limited number of referral maternities (EmONC) on which to focus resources to ensure the facilities are able to cover the population within one or two hours of travel time. ● The model is built on new programmatic approaches to strengthen routine management and use of maternal, newborn, and reproductive health data and leverages the concepts of implementation research to improve quality of care in referral maternity facilities. | <p>UNFPA, Implementation manual for developing a national network of maternity units: Improving EmONC, UNFPA, New York. 2020</p> |
| <p>EmONC programme and assessment</p> <p>One of the strategic interventions under UNFPA Country Programme 8 (CP8) for increasing the national and district capacity to deliver comprehensive high quality maternal health services were to:</p> <ul style="list-style-type: none"> ● Functionalise Health Centre (HC) IVs ● Provide the basic amenities and infrastructure to support provision of EmONC services in 25 UNFPA target districts with equipment as per MoH standards ● Provide technical support for continuous quality improvement of SRH services with special focus on 34 target districts ● Enhance performance of midwifery services in underserved areas. <p>Achievements (percentage):</p> <ul style="list-style-type: none"> ● 8 per cent of HC IIIs with capacity to provide EmONC (below target by 72 per cent) ● 7 per cent of HC IVs with capacity to provide EmONC (below target by 53 per cent) ● 7 per cent of hospitals with capacity to provide EmONC (below target by 93 per cent) ● “UNFPA invested more in upstream activities such as support to MoH in formulation of SRH policies and guidelines than in downstream ones such health staffing, equipping health facilities, setting up blood transfusion facilities, which would have had more direct impact on the capacity for EmONC. For significant improvement of EmONC provision to happen, UNFPA needs to invest in advocacy in the following game changers: | <p>GoU and UNFPA, UNFPA 8th Country Programme, 2016-2020 Evaluation Report, Uganda, 2020</p> |

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- **Strong advocacy to MoH and DLGs** for the recruitment and deployment of critical staff cadres to those HC IVs without - anaesthetists, laboratory attendants /technicians, theatre attendants, medical officers
- **Upgrading of some HC IIIs into HC IVs** especially in the hard-to-reach areas to improve coverage
- Provision of essential medical **equipment** items and especially those directly related to EmONC
- Setting up of a sustainable **ambulance referral system** to allow mothers with complications to be referred from lower-level HCs to higher ones” (p.54)

The following are entries for EmONC activities under the 2019 MHTF annual report:

- “UNFPA supported the MoH to **develop the National Policy for Sexual Reproductive Health and Rights** that was approved by Top management at MoH, a Certificate of Financial Implications (CFI) for the National Policy Guidelines for SRHR has been issued by the Ministry of Finance, Planning and Economic Development and following completion of the Regulatory Impact Assessment (RIA), the policy is now ready for presentation to Cabinet for approval and this will be shared after approval. UNFPA is working with relevant departments and division, particularly the Department of Health Sector Strategy and Policy, and the Division of Reproductive and Infant Health to expedite the process of submitting the SRHR policy to the Cabinet.
- UNFPA supported the RMNCAH (Reproductive, maternal, newborn, child, and adolescent health) Assembly, the 3rd National Family Planning Conference, and Network of African Parliamentary Committees on Health (NEAPACOH) conference, and resolutions and commitments were made on **how to advance the RMNCAH agenda**. For example, NEAPACOH committed itself towards increasing advocacy for domestic financing for SRH/FP including the fast-tracking enactment and implementation of the National Health Insurance Scheme (NHIS) Bill, which has now been approved by cabinet.”
- “UNFPA with support from Governments of Netherlands and Austria is going to **scale up Quality Improvement approaches (CQI)** to enhance achievement of better health outcomes and greater efficiency in the delivery of quality services to address gaps impeding delivery of quality ANC, labour and delivery, and newborn care services in the target districts.” (p.4)

UNFPA Uganda, 2019 Annual MHTF Report, 2019

The following is the entry for EmONC in the MHTF 2018 annual report:

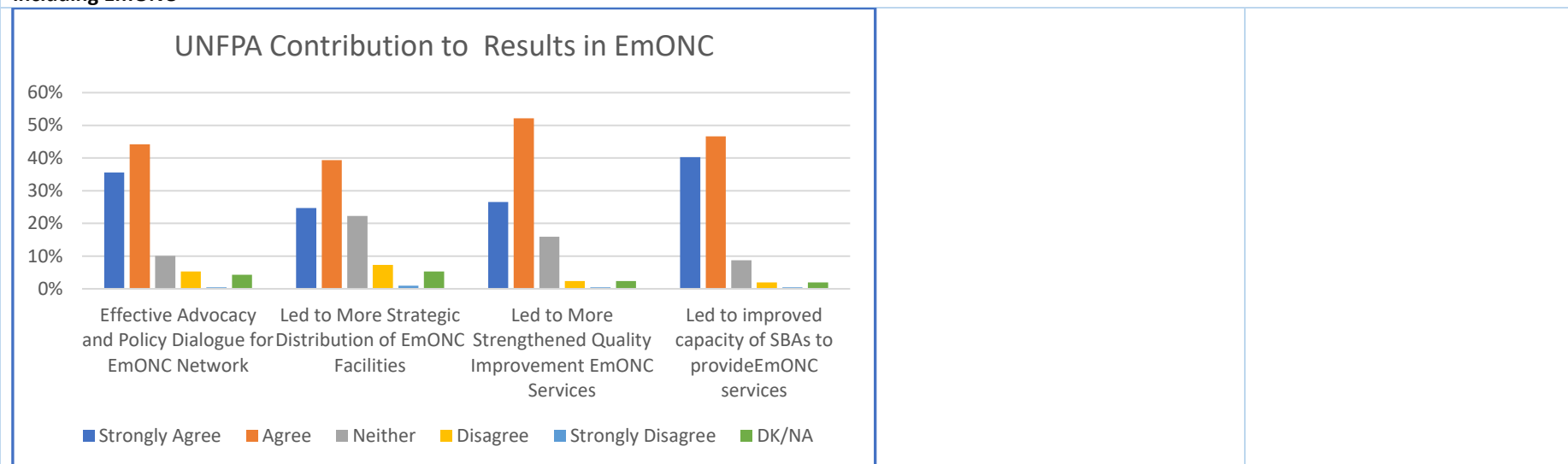
- “The National Policy for Sexual Reproductive Health and Rights which has been under review was approved by top management of MoH. However, the element of delivering family planning services to adolescents/young people under 15 years of age still poses a challenge. The Uganda Demographic Health Survey (UDHS) 2016 results showed that Uganda still has high teenage pregnancy rate at (25%) and 48% of Uganda’s population is aged 0-14 years. As the country strives to improve family planning utilization and uptake, the sexually active adolescents should be brought in context to avoid associated consequences. The **MoH in partnership with UNFPA has trained Trainer of trainers** from MoH, districts, implementing partners (IPs) both in humanitarian and development in Minimum Initial Service Package (MISP) for SRH and clinical care prevention and management of GBV survivors. The training underscored the need for **integration and provision of quality Emergency Obstetric and Neonatal care services** to reduce on maternal and newborn morbidity and mortality. Advocacy for inclusion of MISP in pre-service training in curriculum of Medical schools, Tutor colleges and midwifery schools was done through meetings with the heads of training in Ministry of Education, tutor college principals and Deans of the schools of Health sciences, Public health in Makerere University.” p.3

UNFPA Uganda, 2018 Annual MHTF Report, 2018.

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| <p>Assumption 2.1: MHTF efforts at global, regional, and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC</p> | |
| <ul style="list-style-type: none"> ● “Bottlenecks to achieving effective coverage of high impact Maternal Newborn Health interventions at scale have been identified in the 2016 Reproductive Maternal Newborn Child Adolescent Health (RMNCAH) Investment case. These include leadership, human resources, service delivery, information systems, supply chain and economic access among others. Therefore, urgent effort is needed to first tackle the immediate causes of death for the majority of women and newborns, while putting in place longer-term efforts to strengthen the health system and working on the social determinants that majorly lie outside the health sector.” (p.2) | <p>UNFPA and MoH Uganda, Assessment of quality and coverage of EmONC services in 25 targeted districts, 2017, p.2</p> |
| <ul style="list-style-type: none"> ● Sida has funded UNFPA to implement MNH activities as part of an integrated SRHR programme, in Phase I: 2013-2014, and Phase II: 2015-2017. Support for MNH activities was supposed to be phased-out in Phase II but was then carried-over in the new GBV-focused joint UNFPA-UN Women programme that started in 2018. | <p>Interview with bilateral donor, Kampala, May 2021</p> |
| <p>Zambia</p> | |
| <p>Zambia programme decision related to mapping EmONC national network with GIS technology</p> <ul style="list-style-type: none"> ● UNFPA Zambia declined to use MHTF funds to support GIS technology to map the EmONC network of facilities. Instead, it works with the provincial health offices as they know the facilities and the people. Not all facilities manage deliveries; some offer SRH services, but not maternity services. | <p>Interview, UNFPA Zambia national staff. August 2021.</p> |
| <p>EmONC functionality assessments</p> <ul style="list-style-type: none"> ● EmONC is considered one of the areas that has been identified as key to ensuring that UNFPA is able to deliver on one of the transformational results – zero maternal deaths. The resources that come from MHTF, enable us to assess facilities to look at the readiness of facilities to provide EmONC. With the assessments, MHTF funds are used to obtain equipment needed. | <p>Interview, UNFPA Zambia staff. August 2021.</p> |
| <p>EmONC functionality assessment</p> <ul style="list-style-type: none"> ● UNFPA supported an assessment of EmONC functionality that identified various gaps, such as the lack of equipment and skills among health workers to perform all signal functions. | <p>UNFPA, Zambia. 2019 Annual Report. 2020.</p> |
| <ul style="list-style-type: none"> ● “To increase the number of health facilities providing quality Emergency Obstetric and Neonatal Care (EmONC) services according to international standards, 162 health facilities in Central, Western, and Luapula Provinces were assessed for EmONC functionality including the status of other RMNCAH&N services to inform programme improvement. Key gaps noted in the provision of EmONC services include non- availability of skilled staff, incomplete emergency management kits for eclampsia and post-partum haemorrhage (PPH) as well as inadequate knowledge and skills among health facility staff to perform selected EmONC procedures such as MVA, cervical tear repair and use of anti-shock garments. To address these gaps, the capacity of 37 health workers to provide quality EmONC and other SRH services was enhanced through training, an additional 28 qualified as mentors in EmONC, and 64 nurses qualified as midwives. In addition, assorted RH equipment for targeted facilities were procured. Further, in order to respond to MPDSR reports that show that more than 85% of maternal deaths occur in health facilities, especially hospitals (CEmONC facilities), support was provided for the establishment a triage system and high dependence units in 10 districts of Central and Western province to improve the care of women with complications related to pregnancy and childbirth.” | <p>UNFPA, Zambia. 2019 Annual Report. 2020. pp.1-2</p> |

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| <ul style="list-style-type: none"> ● “An EmONC functionality assessment was undertaken in Central, Luapula and Western Provinces to ascertain the availability of equipment, infrastructure and medical/surgical supplies. In addition, an evaluation of the level of competencies for all the members of staff trained/mentored in EmONC was conducted to facilitate provision onsite technical support and make recommendation for better service provision. ● Key gaps noted in the provision of EmONC services include non-availability of skilled staff, incomplete emergency management kits for eclampsia and PPH, as well as inadequate knowledge and skills among health facility staff to perform selected EmONC procedures such as MVA, cervical tear repair and use of anti-shock garments. It was also observed that most facilities lacked EmONC equipment such as MVA Kits, suturing equipment and supplies. To address these identified challenges, UNFPA will in 2021 distribute the already procured MVA equipment under Access Project and build capacity of health care providers in provision of BEmONC services such as CAC provision, Neonatal resuscitation and provision of essential medicines such as Magnesium sulphate for eclampsia. (p.3) | <p>UNFPA, Zambia. MHTF Annual Report, 2020. Undated.</p> |
| <p>National Respectful Maternal Care Guidelines</p> <ul style="list-style-type: none"> ● UNFPA supported the MAZ to organize and conduct, in collaboration with the MoH, a five-day workshop to develop Respectful Maternity Care (RMC) Guidelines. “Zambia is the first country to develop RMC guidelines as most countries have developed advocacy toolkits and training guides.” Participants were from the MoH, the Women and Newborn Hospital – University Teaching Hospital, Ministry of Defence, General Nursing Council of Zambia, Jhpiego, USAID/JSI Deliver, the MAZ National Executive Board, educators from midwifery colleges and senior midwives from Southern, Western, Eastern and Central Provinces. | <p>Midwives Association of Zambia. Development of National Respectful Maternity Care Guidelines Report. 2019.</p> |
| <p>Online survey</p> | |
| <p>Question 7:</p> | <p>Online Survey conducted between May and July 2021</p> |

Assumption 2.1: MHTF efforts at global, regional, and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC



| Contributions in EmONC | Strongly Agree | Agree | Neither | Disagree | Strongly Disagree | Don't know/ NA |
|--|----------------|--------|---------|----------|-------------------|----------------|
| Effective Advocacy and Policy Dialogue for EmONC Network | 35.58% | 44.23% | 10.10% | 5.29% | 0.48% | 4.33% |
| Led to More Strategic Distribution of EmONC Facilities | 24.76% | 39.32% | 22.33% | 7.28% | 0.97 per cent | 5.34% |
| Led to More Strengthened Quality Improvement EmONC Services | 26.57% | 52.17% | 15.94% | 2.42% | 0.48 per cent | 2.42% |
| Led to improved capacity of skilled birth attendants to provide EmONC services | 40.29% | 46.60% | 8.74% | 1.94% | 0.49% | 1.94% |

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| Indicators: | |
| <ul style="list-style-type: none"> ● Examples of MHTF efforts to strengthen QI processes, tools and data collection at national and sub-national level ● Views of health officers at national and sub-national level in geographies supported by UNFPA, which confirm implementation of QI monitoring on a regular basis and the utilisation of findings to support improvements in services ● Examples of how QI efforts incorporate MHTF core principles, human rights and gender equality within supervision and mentorship ● Views of health officials, including facility managers, providers, and community members regarding how SRHR and MNH services, including EmONC services, are monitored to ensure quality ● Availability of plans to sustain (institutionalize) UNFPA-supported QI processes within national performance and supervision systems. | |
| Observations | Sources of evidence |
| Global | |
| <ul style="list-style-type: none"> ● In 2019, 80 per cent of the 32 MHTF-supported countries have integrated respectful maternity care, safe abortion care (to the full extent of the law), cervical cancer, fistula and HIV prevention as part of the pre-service curriculum and in-service training: 28,800 midwives were educated and trained; 400 midwifery schools received training equipment, simulation models and books, and 2,700 midwifery tutors benefited from upgrades in teaching and clinical skills; 12 out of 32 countries featured EmONC facilities with 100 per cent met need for midwifery staffing. In several of MHTF supported countries, 50 per cent of the population are now able to reach EmONC facilities within two hours of travel time. | UNFPA, MHTF Narrative 1st draft, New York, 2020 |
| <ul style="list-style-type: none"> ● Only recently have women started to speak about being mocked, scolded, insulted and yelled at by health-care workers. Particularly sexist and offensive remarks were also reported. Testimonies from women in Honduras reported comments such as “you didn’t cry when you did it, open your legs or your baby will die, and it will be your fault”. One health-care worker remarked to an adolescent girl giving birth, “you didn’t shout when the penis was inside you, why do you shout now?” Women of lower socioeconomic status have described being humiliated by health workers for their poverty, for their inability to read or write, for residing in rural or slum areas or for being dirty or unkempt. 36 women have also described experiencing threats of withholding treatment or of physical violence or poor outcomes by health-care providers during childbirth, including threats of beatings if they are non-compliant, and being blamed for their situation. | UNGA, A human rights-based approach to mistreatment and violence against women in reproductive health services, UNGA, New York, 2019 |
| <ul style="list-style-type: none"> ● Towards that end, UNFPA joined the WHO and UNICEF in 2017 to fund the Quality of Care Network for Maternal, Newborn, and Child Health (http://www.qualityofcarenetwork.org/). Nine countries supported by the MHTF are already part of the network and more are joining it. | The MHTF UNFPA, Annual Report 2018, 2019, New York |
| <ul style="list-style-type: none"> ● The programme is going well but the critical phase is the monitoring. It is critical that monitoring is adequately funded and there is support from the UNFPA CO, the MoH and the UNFPA regional office. ● Prioritising the network is one thing, but monitoring it is the critical link to impact. ● EPMM indicators will attract more countries and really, we need to build a wider network of partners – for example with the World Bank – to support investment. ● Huge scope to expand this work. But the mapping is a tool. What happens with the tool is the critical point. | Interview Global Technical Partner, September 2021 |

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| <ul style="list-style-type: none"> Shifting networks of care: need to be women centred. Adjust in each country depending on needs, culture, preferences. Need more involvement and leadership from partner countries. GIS mapping is great and very energising but if women do not use the services, it is of limited help. Need to understand and shape patterns of use (quality of care is a major factor). Geography is not the only determinant. | Interview global technical/ multilateral partner, September 2021 |
| Regional | |
| <ul style="list-style-type: none"> Supporting other countries to implement the MHTF-defined approach to EmONC development requires additional experts in UNFPA regional offices to provide consistent technical support, covering aspects from identifying the national EmONC network to monitoring key SRH indicators in health facilities to setting up quality improvements, including with the support of mentors. The regional office of West and Central Africa has started organizing a regional group of experts to support. | The MHTF UNFPA, Annual Report 2018, UNFPA, New York, 2019 |
| Bangladesh | |
| <ul style="list-style-type: none"> A lot of people are working towards EmONC- both international and national agencies. But no one is as focused and as serious as UNFPA. That is because UNFPA listens to voices in the field and its technical team is very dedicated. It closely monitors progress of whatever programmes it puts in place, and makes programme implementors accountable, providing the right support to help them overcome difficulties. | Immediate Past President, Obstetrical and Gynaecological Society of Bangladesh (OGSB), Dhaka, Bangladesh, June 2021 |
| Benin | |
| <ul style="list-style-type: none"> The BEmONC/ CEmONC network did not consider the transport to the referral hospital, and it would be necessary to recheck whether structures around the hospital can refer in less than one hour. The health map should be reorganized according to the BEmONC/ CEmONC distance. In some departments, the state of the roads is mentioned as a problem, calling for better consultation with the government sectors in charge of land use planning. | Interview, MoH management staff, Cotonou, Benin, May 2021 |
| Système de qualité-assurance mis en place par MHTF : Monitoring SONU | |
| <ul style="list-style-type: none"> La fiche de monitoring interroge la qualité des prestations et identifie les goulets d'étranglement (évalue le niveau de disponibilité du staff et intrants ainsi que l'impact de l'absence en tant que complications et décès) : Données analysées pour identifier pourquoi certaines formations SONU ne sont pas fonctionnelles et l'établissement d'un Plan d'amélioration de la qualité | Entretien, UNFPA Staff, Mai 2021, Benin |
| Exemple de l'utilisation de la Fiche de Monitoring développée par le MHTF | |
| <ul style="list-style-type: none"> Quand le DDS (Directeur Départemental de la Santé) ou la sage-femme zone vient faire la supervision, on remplit la fiche SONU : C'est très utile, quand certaines fonctions SONU ou intrants manquent, on fait tout pour se mettre à jour et mettre en pratique les recommandations. Par exemple, pour les intrants : s'il y a un manque de médicaments traceurs, on peut mettre ça dans la pharmacie | Entretien, sage-femme, Juin 2021, Benin |
| Exemple au niveau d'un centre hospitalier | |
| <ul style="list-style-type: none"> La fiche de monitoring utilisée par semestre, mais plutôt au niveau inférieur ; chaque semestre équipe de zone sanitaire vient faire monitoring pour améliorer prise en charge et les indicateurs nous permettent de prendre des actions sur la base des recommandations faites. Par exemple le monitoring a permis de réorganiser le renouvellement des kits d'urgence afin que les produits d'urgence soient toujours disponibles | Entretien, Centre de Santé, Management, Mai 2021, Benin CHU |

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| <p>Défi du monitoring : Limitations de la fiche de monitoring :</p> <ul style="list-style-type: none"> ● L'analyse des données donne une idée de la qualité des services... Mais si on veut mesurer la qualité, il faut aller au-delà de l'outil pour voir plus en profondeur ce qui se passe sur le terrain – la fiche est un premier pas, mais si on veut parler de qualité, il faut aller plus loin. La fiche ne rentre pas dans les éléments qui permettent de savoir si le centre est fonctionnel ou pas. ● Il y a aussi un défi en termes de capacité d'analyse des données : Comment les données sont analysées et qu'est ce qui est fait pour combler les manques ? L'analyse n'est pas appropriée par les partenaires. On a besoin de formations pour analyser les données et prendre les décisions nécessaires. <p>La fiche ne mesure pas les problèmes de RH – c'est la prérogative du gouvernement.</p> | <p>Entretien, UNFPA bureau pays, Juin 2021, Benin</p> |
| <ul style="list-style-type: none"> ● Il faut nuancer les conclusions que l'on tire de ces fiches. La vraie question étant : Quand certaines fonctions SONU ne sont pas mises en œuvre : Pourquoi ? Est-ce un problème de compétences ? D'équipements ? Cette analyse fine n'est pas faite. La fiche est intéressante, mais la manière dont on utilise les conclusions est la clef. | <p>Entretien, Donateur bilatéral, Juillet 2021, Benin</p> |
| <p>Limites du monitoring</p> <ul style="list-style-type: none"> ● Le monitoring permet de vérifier si on a respecté les processus et toutes les étapes. On peut avoir un bon monitoring mais les résultats sont mauvais à cause d'une mauvaise organisation du travail et une faible qualité des prestations des sage-femme ● Le monitoring pointe sur les déficiences, mais il y a un challenge dans la capacité à combler les déficiences en ressources humaines et plateaux techniques. Il faut un engagement fort du gouvernement. | <p>Entretien, National Ministère de la Santé Manager, Mai 2021, Benin</p> |
| <p>Défi – fonctionnalité des formations SONU</p> <ul style="list-style-type: none"> ● Ressources Humaines – il y a moins de déficits en sage-femme au niveau des formations SONUS, mais le défi est que les formations sanitaires SONU soient fonctionnelles et puissent remplir toutes les fonctions signalétiques ● La disponibilité des produits vitaux n'est pas bonne – ruptures de stock | <p>Entretien, UNFPA bureau pays, Mai 2021, Benin</p> |
| <p>Bâtiments pas aux normes</p> <p>Les institutions financières [PTFs] ne construisent pas mais font des réhabilitations. C'est un problème car réhabiliter n'apporte pas grand-chose souvent ; les bâtiments ont été construits il y a longtemps et répondaient à des besoins différents, sur la base d'une population moindre et il faut reconstruire dans certains cas ; si vous accompagnez quelqu'un pour atteindre ses objectifs, il faut se donner les moyens d'atteindre les objectifs »</p> | <p>Entretien, Département de la santé du district, Mai 2021, Benin</p> |
| <p>Défi : Aspect communautaire des SONU pas suffisamment développé - n'adresse pas le problème du premier retard</p> <ul style="list-style-type: none"> ● Le vrai problème c'est le retard aux soins c'est le premier retard. La femme fait son travail à la maison et ne vient que vers la phase d'expulsion. Elles disent que quand elles viennent tôt, elles durent trop ici. Les gens pourront alors penser qu'elles ne se sont pas courageuses. | <p>Entretien sage-femme, Centre de santé, Mai 2021, Benin</p> |
| <ul style="list-style-type: none"> ● On voit USAID et UNICEF mais au niveau communautaire, UNFPA n'est pas très présent. Et vous savez il faut agir aussi sur les retards. Tout ne se passe pas dans la clinique, tout ne se passe pas dans la salle d'accouchement. Il y a beaucoup de choses en amont. Moi je voudrais souhaiter que les SONU communautaires soient repris par UNFPA et je tire vraiment la sonnette d'alarme sur le fait que tel que ça va se passer avec la nouvelle stratégie, s'il n'y a pas un minimum de choses pour | <p>Doneur bilatérale, Juin 2021, Benin</p> |

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| <p>garantir la survie de la mère et de l'enfant, ça peut créer des difficultés dans la mise en œuvre de notre programme communautaire, on a remarqué que les SONU communautaires constituaient la partie un peu faible parce que les relais sont beaucoup attirés par les pratiques de traitement, les pratiques curatives, mais que sur les activités de promotion où ils doivent également conseiller les femmes enceintes et les mères à dormir sous moustiquaires, faire la communication, le suivi des enfants, ne sont pas très bien faites. Est-ce que c'est la formation qui a problème ? est-ce que c'est parce qu'ils sont pris pendant tout le temps ? quand on pose la question, les superviseurs disent que c'est parce qu'ils sont plus attirés par les autres interventions. Donc on a remarqué que ces SONU communautaires sont moins réussis que les autres activités du programme communautaire.</p> | |
| <ul style="list-style-type: none"> En ce qui concerne particulièrement les questions de mortalité maternelle, c'est le premier retard. La prise de décision pour aller au centre de santé. Ce facteur peut être lié à d'autres comme la disponibilité de personnes non compétentes dans la communauté, la perception que les gens ont des agents de santé etc. Au niveau des formations sanitaires, il y a toute une série de problèmes en relation avec l'organisation des services, la disponibilité et la qualité du personnel soignant et la disponibilité des intrants, je veux parler du matériel et des médicaments et autres produits. | Entretien, Doneur multitérale, Juin 2021, Benin |
| <p>Rôle de l'entourage de la femme enceinte</p> <ul style="list-style-type: none"> Ce centre est bien connu dans notre arrondissement. Donc quand une femme tombe enceinte, c'est ici qu'elle vient directement. Même si toi-même tu ne veux pas venir, les gens autour de toi vont te demander de venir. Par exemple, le mari ou une tante ou quelqu'un va te dire d'aller faire voir la grossesse par une sage-femme Moi, c'est mon mari qui m'a amené ici. Dès que je lui ai dit que j'avais un arrêt, il a dit qu'on doit aller voir la sage-femme | Discussion de groupe soin prénatale, Juin 2021, Benin |
| <p>Addressing challenges with practical solutions:</p> <ul style="list-style-type: none"> The two leading causes of death are haemorrhage and eclampsia, so the first solution is to work on the availability of products: Blood (overall, blood products are available but do not reach the user); this should be part of a kit. The second solution is to work on the referral system: It is not only the mode of transport, but also the conditions of transport. There are four ambulances in the department – we do not necessarily need an extra ambulance, but we need to organize ourselves better. The Government has planned to set up an automated ambulance management centre. Finally, there are a lot of HR issues that need to be addressed. For example, ensure that a gynaecologist is always present in tertiary level structures (which is not the case for the moment). | Interview, MoH Management, Cotonou, Benin, May 2021 |
| <p>Challenges:</p> <ul style="list-style-type: none"> The absence of magnesium sulphate leads to deaths from eclampsia; most centres lack it, but sulphate is available centrally; why are we not reacting? | Interview, Clinic Manager, Benin, May 2021 |
| <p>Défis : Equipement au niveau hospitalier</p> <ul style="list-style-type: none"> Notre service de réanimation est en difficulté en raison d'infrastructures dépassées (quand il pleut, des lits de réanimation ne sont pas utilisables – il aurait fallu refaire tout le bâtiment ; difficulté en Mars Avril Juin car il y a une grande affluence et pas | Entretien Hospital Director, Mai 2021, Benin |

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| assez de place – certaines femmes doivent être renvoyées, même si c’est trop tôt car nous sommes en surcharge. Il y avait un projet dans ce sens. | |
| Sudan | |
| <p>Continued urgent need for improved care</p> <ul style="list-style-type: none"> ● Sudan, with a maternal mortality ratio (MMR) of 311 (95 per cent CI: 214- 433) deaths per 100,000 live births and a 1 in 72 lifetime risk of dying due to pregnancy or childbirth, stands one of the highest in Africa and highest in Northern region of the continent. ● Institutional delivery rate in the health facilities is very low (27.7 per cent). The neonatal mortality rate (MR) was 38 per 1,000 live births in 1999 and 33 per 1,000 live births in 2014 accounting for 44 per cent of total U5MR (68/1000 LB). Up to 50 per cent of neonatal deaths occur in the first 24 hours of life, with over 75 per cent of them occurring in the first week of life. Newborn mortality is a sensitive indicator of the quality of care provided during the antenatal period, delivery and immediate postnatal period. | FMoH, Sudan Standards and Norms for EmONC, 2020, MoH, Khartoum, Sudan |
| <p>Technical interventions to boost quality services</p> <ul style="list-style-type: none"> ● Six comprehensive EmONC facilities in Sudan were fully equipped with high-quality family planning clinics in 2019, and health providers were trained to provide post-partum and post-abortion family planning services. Additionally, 50 health centres instituted cervical cancer screenings using visual inspection of the cervix with acetic acid (VIA) method, and five hospitals were prepared to provide cryotherapy treatment. | UNFPA, MHTF 2019 Annual Report, Sudan. Khartoum, 2020 |
| <p>Police engaged to support health</p> <ul style="list-style-type: none"> ● Some interesting experiences included: Sudan’s partnership with the police to address delays in timely transport to facilities. | UNFPA, MHTF 2019 Annual Report, Khartoum, Sudan. 2020 |
| <p>UNFPA material and other investments to improving care</p> <ul style="list-style-type: none"> ● UNFPA has made some contributions in kind (essential equipment, delivery room furniture and supplies) to support EmONC services in several health facilities including hospitals and PHC centres. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| <ul style="list-style-type: none"> ● UNFPA supports the EmONC assessment, selection of health facilities, improved EmONC services through supporting capacity building programmes, rehabilitation, provision of commodities and supplies and training of EmONC support team and also UNFPA supports the referral system. | UNFPA Country Team Group meeting Khartoum, 5 June 2021 |
| <ul style="list-style-type: none"> ● UNFPA supported training programmes, the provision of commodities and supplies, building and rehabilitation of emergency room and operating theatre, support to referral of patients and staff retention through rehabilitation of the doctor rest area for doctors (to include furniture, wi-fi, facilities for refreshments). | Interview, SMOH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| <ul style="list-style-type: none"> ● UNFPA supported the renovation of the emergency building, the theatre, the family planning centre, the fistula centre and the GBV centre with provision for all necessary equipment. | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021 |
| <p>Limited service availability</p> <ul style="list-style-type: none"> ● All countries provide neonatal and childcare in their public health care facilities whether they are specialized centres, hospitals, or different types of PHC centres. | Kabakian-Khasholian T, and Ali A, UNFPA Assessment of Sexual and Reproductive Health Integration |

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| <ul style="list-style-type: none"> ● Prevention of unsafe abortion and post-abortion care are provided only in Morocco and Sudan. Abortion services are restricted by law in all of these countries. ● In contrast to ANC and PNC and family planning services, other RH conditions such as cervical and breast cancer screening and prevention and management of GBV and sexual health conditions are not universally available at PHC facilities. ● BEmONC is provided mainly in hospitals. The provision of CEmONC through PHC centres is virtually non-existent. In all countries, CEmONC is provided in hospitals and similar facilities in the six countries, with the exception of the PHC centres in ... Sudan. | <p>in Selected Arab States, The Middle East and North Africa Health Policy Forum (MENA HPF) and UNFPA Arab States Regional Office, Cairo, December 2017. p.22</p> |
| <p>UNFPA convenes partners for EmONC development</p> <ul style="list-style-type: none"> ● CO, in collaboration with FMOH and through MHTF support, organized the dissemination of the results of the EmONC Needs Assessment in the presence of His Excellency the Minister of Health and more than 80 participants from national and subnational levels and technical and financial partners. ● Representatives from UNFPA HQ, UNFPA ASRO, Averting Maternal Death and Disability (AMDD)/Columbia University, and ICDDR, Bangladesh participated in this dissemination and facilitated a three-day national advocacy workshop in August 2018 on EmONC development, involving senior officials of the FMOH (national and State levels) as well as professional associations and civil society organizations. ● This was followed by state-level ‘advocacy workshops’ in four states (as a start) conducted by a national team of experts who worked on the EmONC assessment. | <p>UNFPA, MHTF Annual Report: Sudan, 2018, Khartoum, Sudan. p.2</p> |
| <p>UNFPA advocacy and coordination support to EmONC delayed due to COVID-19</p> <ul style="list-style-type: none"> ● Due to the COVID-19 context, and the competing priorities of the country to respond to the pandemic, some activities were delayed from 2020: <ul style="list-style-type: none"> ○ Coordination meetings for the EmONC stakeholders at national levels, including report development and sharing ○ Advocacy interventions targeting senior government officials, stakeholders, partners and donors to deploy graduated midwives to the selected EmONC facilities. | <p>UNFPA, MHTF Mid-Year report for 2020, 2020, Khartoum, Sudan</p> |
| <p>UNFPA supports quality monitoring and evaluation</p> <ul style="list-style-type: none"> ● UNFPA supported development of a quality package to monitoring and evaluation, which aims to build the capacity of the support team responsible for monitoring and evaluation activities at both federal and states level. ● Eighteen states were targeted. | <p>Interview, RH Team, FMOH, Khartoum, Sudan, 1 June 2021</p> |
| <p>Recommendations from the EmONC Facility Network Mapping and Assessment Process</p> <ul style="list-style-type: none"> ● Strengthen the 204 “almost there” health facilities (191 hospitals and 13 health centres) to meet the minimum recommended number of EmONC facilities. ● Decisions for which facilities to upgrade first should be based on suitable criteria such as staffing, case load, equipment requirement, proximity to referral facilities, availability of ambulance, etc. ● All nurses, midwives, and clinicians should be equipped, mentored, and supported to perform all EmONC signal functions for a BEmONC facility. ● Emphasize the use of best practice guidelines including the use of oxytocin and magnesium sulphate. | <p>MoH, Mapping and Assessment of Maternal, Neonatal and Child Health Emergencies and Rehabilitation Services 2017, 2018, MoH, Khartoum, Sudan</p> |

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| <ul style="list-style-type: none"> Given the importance of the use and completeness of register books, and the lack of data on deliveries, newborn outcomes, complications, maternal and newborn deaths, and associated services, the MoH and its partners should mobilize resources to improve data through strengthening the HMIS system and capacity building of health providers in all facilities. | |
| <ul style="list-style-type: none"> UNFPA contributed to the government-led process to conduct initial assessment and gap analysis all over the country in 2017 and supported the dissemination in 2018 and the training on monitoring came after that. Having some concerns about the modality, UNFPA initially supported only one state out of 18 on the capacity building programme of the supporting team who is responsible for implementation of plans in addition to monitoring and evaluation of the intervention. UNFPA was concerned about the approach and the quality of the training as they considered it insufficiently detailed and careful. However, after several discussions, the training programme resumed with a new approach that was more detailed and specific about measuring capacity, the condition of equipment and identifying/grading standards of care. | <p>Interview, RH Team, Federal MoH, Khartoum, Sudan, 1 June 2021</p> |
| Gaps in reporting <ul style="list-style-type: none"> There are chronic problems with lack of data and lack of availability of a systematized register book for deliveries, newborn outcomes, direct and indirect obstetric complications, and maternal deaths. | <p>FMoH, Mapping and Assessment of Maternal, Neonatal and Child Health Emergencies and Rehabilitation Services 2017, FMoH, Sudan, 2018</p> |
| Improving monitoring <ul style="list-style-type: none"> EmONC network development helped identify the prioritized health facilities for BEmONC & CEmONC It was also a chance for capacity building for senior health staff Next steps include validation and endorsement at state level (few states already did this) and then a national EmONC upgrade plan followed by effective resource mobilization strategy. | <p>Comments, UNFPA CO staff, Khartoum, Sudan, 23 June 2021</p> |
| Needs are complex <ul style="list-style-type: none"> EmONC health facilities proposed by the working group (number of EmONC facilities, referral links, staff, strengths, and weaknesses). The working group of Blue Nile State has selected seven health facilities to be part of the EmONC network, including two CEmONC and five BEmONC. This number is below the international recommendation but above the expected number set by the FMoH of five designated EmONC health facilities. The referral linkages between the selected BEmONC and CEmONC health facilities are difficult due to financial barriers, poor road network, especially during the heavy rainy season, and insecurity. Major gaps include the absence of ICU and HDU, shortage in surgical equipment, oxygen supply, equipment for assisted vaginal delivery. The lack of latrines and electricity has also been highlighted in most health facilities. In terms of management and monitoring of the designated EmONC health facilities, the working group highlighted the absence of supportive supervision, health facility registers, and monitoring dashboard. However, coordination staff meetings are held in all designated facilities, led by the medical doctor(s). | <p>FMoH and UNFPA, EmONC Prioritization Technical report: State Level Analysis, 2017-18, Khartoum, Sudan</p> |

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| <p>Workshops for the development of the national EmONC network</p> <ul style="list-style-type: none"> ● National workshop for the presentation of the EmONC development approach and monitoring (14-16 August 2018) <ul style="list-style-type: none"> ○ Following the EmONC dissemination workshop, the MCH Directorate of the FMoH and UNFPA co-chaired a workshop on EmONC development with about 60 participants, including representatives from the FMoH and from the 18 States (RH coordinators, child health coordinators), representatives of professional associations, and technical and financing partners (UNFPA, UNICEF, Italy, Sudanese American Medical Association). ○ The objectives of the workshop were: (1) To define the approach for the development of the national network of EmONC facilities in Sudan, (2) To analyse the results of the EmONC and make preliminary recommendations to address gaps in human resources, availability of essential medicines, infrastructure, and referrals. ● National technical workshop on the development and monitoring of the national network of EmONC facilities (06-08 November 2018) <ul style="list-style-type: none"> ○ This workshop aimed to ... get a common understanding of the health management information system in Sudan (HMIS/DHIS2) and the monitoring processes of health facilities already in place... and define the approach for monitoring the national network of EmONC facilities (from data collection to analysis and response) and the key MNH/RH indicators to be monitored in EmONC facilities (national ‘monitoring sheet’). ○ This workshop was co-led by the FMoH and UNFPA and was attended by MNH technical staff from the FMoH (including from HMIS); two participants from each state, including the directors of RH; UNFPA, WHO, UNICEF, NGOs; private sector focal persons. | <p>FMoH and UNFPA, EmONC Prioritization Technical report: State Level Analysis, 2017-18, Khartoum, Sudan</p> |
| <p>Rehabilitation of health facilities creates opportunities for integration</p> <ul style="list-style-type: none"> ● Health facilities in targeted areas to provide cervical cancer screening services and also health facilities which will provide confirmation tests for suspected cases and management services for precancerous lesions have been identified. ● The screening will be integrated into other SRH services, like family planning, ANC, post-natal care and EmONC. ● Also, referral pathways for management of cervical cancer cases that need advanced interventions were identified. ● Essential cervical cancer prevention and pre-cancerous management equipment and supplies were procured and will be deployed after the health facilities assessment. Procurement of some consumables was initiated in 2019. | <p>UNFPA, Prevention of Uterine Cervical Cancer in East Sudan, 2019, UNFPA, Khartoum, Sudan</p> |
| <p>Referral networks are multi-directional</p> <ul style="list-style-type: none"> ● 55 facilities covered 74 per cent of the population within 2-hour travel time. The national network was finalised in 2019. Phase III of the development process is to move forward and connect these EmONC centres to PHC centres and to start monitoring and upgrading the quality of care offered in EmONC facilities. ● EmONC facilities also need onward referral links to be more clearly established. For some of these links, other ministries are needed to be involved, including Ministry of Infrastructure, Social Protection, and they have been included in the process. | <p>Webinar presentation, FMoH, Khartoum, 17 June 2021</p> |
| <p>Blue Nile State: referral hospital investments</p> <ul style="list-style-type: none"> ● Aldmazeen hospital: no ICU beds in the obstetrics-gynaecology ward. HDU is for less serious cases than ICU. | <p>Interview, Research-practitioner, Khartoum, Sudan, 15 June 2021</p> |

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| <ul style="list-style-type: none"> There are incubators for newborns but “not functioning well”. The baby warmer is not working. HDU beds are used for eclampsia patients. Sometimes the anaesthesiology machine from the theatre is used for monitoring patients. | |
| <p>Khartoum State referral hospital: infrastructure affects quality</p> <ul style="list-style-type: none"> Limited number of health staff especially in the last two years mainly due to recurrent strikes Limited resources including beds and consumables caused by shortage of supplies and increasing patient demand Limited beds in the nursery for a long time as the main nursery is under rehabilitation Unsustainable ICU services due to turn-over of staff and no support to retain them Hot and cold gynaecological operations including abortion services have been suspended due to COVID-19, and health staff strikes have happened in the last year. In addition, the building is under rehabilitation. | Interview, Referral Hospital Medical Director, Sudan, 5 June 2021 |
| Women are frequently denied their right to make informed decisions about the healthcare they receive during childbirth and other reproductive health services; this lack of informed consent constitutes a human rights violation that could be attributed to states and national health systems. Manifestations of mistreatment and GBV in reproductive health-care services and during facility-based childbirth... | UNGA, A human rights-based approach to mistreatment and violence against women in reproductive health services, 2019, New York |
| Togo | |
| <ul style="list-style-type: none"> In 2019, four countries monitored key reproductive MNH indicators in their national network of EmONC health facilities, including EmONC indicators: Benin, Burundi, Guinea and Togo. District, regional and national teams analyse consolidated EmONC data and define responses to address gaps at their levels. This bottom-up approach is a paradigm shift in most countries that has defined a national EmONC network. Only Togo, however, has currently reached the stage of analysing data and defining responses to improve the quality of care. While the share of the population able to access a nearby EmONC health facility is high in Benin and Togo (94 per cent within one hour of travel time in Benin and 80 per cent within one hour in Togo), the proportion of expected births taking place in EmONC health facilities is still very low in the two countries. This reflects issues linked to financial access and quality of care. | The MHTF UNFPA, Annual Report 2019, 2020 |
| <ul style="list-style-type: none"> A rising number of institutional births has generated an increased focus on the quality of care for women and their newborns in many MHTF -supported countries. In 2018, Burkina Faso, Burundi, Niger and Togo started systematically documenting the case fatality rate from direct obstetric complications in EmONC facilities, gaps in midwives, stock-outs of life-saving commodities, the number of maternal deaths notified, and the numbers reviewed. They also focused on mentorship for both pre-service and in-service midwives as well as capacity-building for teachers. | The MHTF UNFPA, Annual Report 2018, 2019 |
| <ul style="list-style-type: none"> Les actions catalytiques que l’UNFPA a eu à mener, c’est particulièrement dans le cadre des SONU. Aujourd’hui, la Coopération Allemande intervient aussi depuis quelques années. Tout le travail que l’UNFPA avait fait en amont, surtout en termes de cartographie des SONU, a permis d’orienter les interventions de la coopération allemande aujourd’hui. Leurs interventions se font dans la région de la Kara au nord. Ils interviennent à deux niveaux : | UNICEF staff, UNICEF, Togo, June 2021 |

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| <ul style="list-style-type: none"> ○ Il y a le KFW qui s'occupe des SONU et la GIZ qui s'occupe des soins maternels et donc qui sont en train de renforcer les structures périphériques. Ce sont des actions qui ont été bâties sur ce que l'UNFPA a fait entre 2013-2014 (cartographie des SONU). ○ Entre 2014 et 2018, le Togo a fait des avancées majeures en termes de santé maternelle et néonatale. C'est avec l'appui de l'UNFPA en collaboration avec l'OMS, UNICEF. ● Parlant de la coopération entre l'UNFPA et UNICEF, on a beaucoup travaillé sur les soins du nouveau-né. ● L'UNFPA travaillait beaucoup plus sur l'aspect santé de la mère et SONU et UNICEF travaille sur le renforcement des soins néonataux. Il y avait une programmation conjointe qui permettait aux deux agences de pouvoir travailler dans les mêmes structures pour assurer la complémentarité au regard de la formation des prestataires mais aussi de la mise à disposition des équipements qui sont offerts à ces établissements pour pouvoir sécuriser les accouchements et mieux prendre soins des enfants. ● Pour la période 2018 à maintenant, c'est la continuité des initiatives qui ont été prises. La cartographie SONU a été plusieurs fois réajustée pour la rendre conforme aux besoins du pays. Il n'a pas de nouveauté. Au niveau de la PF, l'UNFPA continue de travailler sur la distribution à base communautaire en stratégie mobile et avancée. Dans le cadre des SONU, l'agence continue à appuyer le gouvernement dans le renforcement de l'offre des services SONU dans les régions où elle intervient. | |
| <ul style="list-style-type: none"> ● Ce qui a été important C'est les SONU, la prise en charge de l'hémorragie de la délivrance, le tracé du partogramme, les soins après avortement. Après les formations, nous recevons un document de formation, par exemple lorsque nous sommes allés à la formation SONU, nous avons eu le document de formation SONU ou tout a été détaillé lorsque nous revenons par exemple et nous ne comprenons pas quelque chose nous pouvons revoir ces documents pour nous rappeler de temps en temps des formations, de ce qui nous a été donné, nous avons ces documents (la formation en SONU pour la prise en charge des hémorragies liées a la délivrance, le tracé du partogramme, les soins après avortement). | <p>Interview, Midwife in a public health clinic, Togo, June 2021</p> |
| <ul style="list-style-type: none"> ● L'objectif de l'UNFPA est de nous soutenir dans la santé de la reproduction. Donc l'UNFPA nous vient en appui matière de matériels de travail comme les lits d'hôpitaux, les tables examens, tous les matériels que nous devons utiliser en maternité l'UNFPA est présent. En plus ça c'est l'UNFPA qui nous aide dans les intrants en planification familiale. Nous faisons chaque année, une fois par trimestre, des journées portes-ouvertes en planification familiale où femmes viennent recevoir une contraception gratuitement. A chaque trimestre ! Donc nous avons cette activité quatre fois dans l'année et il n'y a pas une année où l'UNFPA n'est pas à notre côté. Elle est toujours là. | <p>Interview, Midwife in a public health clinic, Togo, June 2021</p> |
| <p>National: Uganda</p> | |
| <p>Support for national strategies to advance quality improvement approaches in maternal care:</p> <ul style="list-style-type: none"> ● UNFPA supported implementation of the quality improvement approaches both at national and sub-national to address gaps in the quality of ANC, labour and delivery, postnatal and newborn care services. At national level, UNFPA supported revision of the National Quality Improvement Strategy and Framework 2020- 2025 and the finalization and launch of the Patient's charter on the World Patient's Safety Day commemoration. UNFPA also supported MoH to update the QI training packages | <p>UNFPA Uganda, Final Annual Report for MHTF, 2020</p> |

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| <p>and trained 50 national and regional trainers. Training was provided to 1,230 health personnel in quality improvement in maternal health, family planning, post abortion care and SGBV screening and treatment.</p> <ul style="list-style-type: none"> • Additionally, 521 health personnel have been trained on data management, capture and analysis in relation to QI. (Support for these activities came from the Netherlands and Austria.) | |
| <ul style="list-style-type: none"> • The quality improvement framework and strategic plan for 2016-2020 was revised with support from USAID ASSIST project based on an evaluation that identified lessons from implementation of the previous framework and plan. The goal of the framework is to: <ul style="list-style-type: none"> ○ Strengthen leadership capacity and support for QI ○ Strengthen documentation, reporting and sharing of QI data and processes ○ Strengthen patient/client-centred care ○ Improve compliance by facilities of service standards ○ Strengthen organizational capacity for QI implementation ○ Promote innovation • The framework describes the content of care (norms, standards, protocols, guidelines) and the process of care (QI approaches and the cycle of learning and improvement) to achieve the outcome of improved quality of care. • Interventions supported by the strategy include the iterative cycle of improvement (plan, do, study, act cycle) and 5S, a methodology that supports a clean, uncluttered, safe and well-organized workspace as a fundamental background for CQI. • Challenges related to implementing QI approaches include the following: <ul style="list-style-type: none"> ○ Insufficient evidence of extent of harmful care (which is thought to be widespread) ○ Political and communication challenges in addressing harmful and wasteful care ○ QI approaches are donor-dependent ○ QI approaches are disease-specific and mainly in the HIV/AIDS space (related to donor dependency). | <p>MoH Uganda, Health sector quality improvement framework and strategic plan, 2015/16-2019/2020, 2016</p> |
| <ul style="list-style-type: none"> • UNFPA supports quality of care, especially in EmONC facilities. For example, during training they support health care workers on how to use the partogram and they support data quality review meetings to improve the accuracy of data (MPDSR). • UNFPA efforts are aligned to the national CQI framework. • The current model of UNFPA supporting strategically the MoH and the districts to conduct activities at the operational level is commendable. “I strongly think that this combination is an area where they can really do well, across the whole area of SRHR, family planning, EmONC. They have not done much under EMONC, but they can also do some, e.g., procuring ambulances.” | <p>Interview, MoH official, Kampala, May 2021</p> |
| <p>Supportive supervision inputs (funded through non-MHTF sources)</p> <ul style="list-style-type: none"> • Supportive supervision is led by the assistant district health officer (ADHO), supported by Marie Stopes Uganda (MSU) through spot checks, as they accompany supervisors on all visits to facilities. During spot checks, MSU uses a check list, which is based on the national tools, but also include specific indicators for the ANSWER project (i.e., related to the voucher programme). | <p>Interview, NGO national staff, Arua District, Uganda, May 2021</p> |

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| <ul style="list-style-type: none"> MSU noted that during the supervisory visit, some facilities requested the districts to provide equipment. The procurement process is through the National Medical Store (NMS); districts lobby and request NMS to send equipment. If they cannot provide the equipment, different partners may provide support, e.g., equipment for deliveries and post abortion care. If something is missing, it is brought up during the quarterly DHO meetings which are attended by partners working the district. UNFPA has not yet informed MSU if and who is going to provide the equipment and commodities requested. | |
| <ul style="list-style-type: none"> MSU conducts supportive supervision with the DHO on a quarterly basis. They also do Joint Clinical Quality Audits (different from CQI). The Clinical Quality Audits are a “top-down” tool to check services against clinical guidelines and standards. | Interview, UNFPA Uganda staff, May 2021 |
| <p>Quality of care issues at service delivery level</p> <ul style="list-style-type: none"> “At the facility level, we have issues with quality of care in EmONC. We have inadequate staff and skills; equipment and supplies are also a gap. Sometimes we have deaths because of lack of equipment and supplies. We have issues of surgical skills for caesarean. At HC IV facilities, the medical officers do not always have the skills as they have not been properly developed at school. We also have a huge gap of anaesthetists, especially at HC IV level where women need them the most. Taking proxy of delivering C-sections and blood transfusion – we are still quite low.” Regarding quality of care, other issues include: <ul style="list-style-type: none"> Lack of transport/ambulance services. Because in many places, the client has to walk to reach the referral facility, because vehicles/ambulances are not available. There are many deaths in transit, and on arrival etc. Issues with the working environment, infrastructure, equipment and commodities Weak diagnostics (skills gaps). Some complications could have been detected earlier – but discovered too late. Local customs: use of local herbs to manage pregnancy and complications. Issues of absenteeism and inadequate numbers of health workers. | Interview, MoH national staff, Kampala, May 2021 |
| <ul style="list-style-type: none"> Providers were asked about activities to improve the quality of services. The following points were made: <ul style="list-style-type: none"> In family planning, mentorship has been conducted by International Rescue Committee. One of the district trainers/mentors (there are two per district) is based in this facility. The ADHO conducts supervision visits on a monthly basis. There is no regular internal supervision/mentoring within the facility. Ways to improve quality are discussed during monthly review meetings in the MCH department. No other QI approaches were mentioned. When asked about data for decision-making, trends in service delivery numbers were noted (e.g., increases in deliveries, abortions, premature deliveries). | Interview, MoH service providers, Lawmo District, Uganda, May 2021 |
| Zambia | |
| MoH perspectives on challenges in MNH and EmONC services | |
| <ul style="list-style-type: none"> There are many things that are contributing to poor maternal outcomes. The most pressing issue regarding maternal health is that the improved indicators do not lead to better outcomes. For example, we look at particular indicators, such as coverage indicators i.e., ANC, things have improved remarkably over a relatively short period of time, more than other indicators. But outcomes remain poor. “Even though we are seeing these women, the service is not up to its best to detect problems as a woman progresses in service delivery. Quality of services is a big problem. ANC first visit = 90 % coverage. Even if they come once, it is up to us to pick up the problem that this woman has, and it is not being done.” | Interview, MoH national staff. Lusaka, Zambia. August 2021. |

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| <ul style="list-style-type: none"> ● When a woman comes for ANC or for whatever service, delivery, PNC anything related to MH, it looks like we lack certain standards of procedures or protocols that should be followed. It is assumed that when someone undergoes training, the provider will do everything they need to do. Protocols or SOPs are not there, the provider is going to provide the service the way they have understood it, and they might have missed something extremely important that might endanger the life of the women. ● Commodities are also a gap; when the HW will write a prescription or advice the client to get the medicine. Commodities such as those to check syphilis and the like. At some point, these problems are still with us. Things related to commodities to treat hypertension, blood. Sometimes they find them, sometimes they do not. Those are the bit issues that are affecting our health service delivery. ● “Demand is also an issue related to health-seeking behaviours in our culture; those beliefs may not necessarily be true. BCC a very big role if there is a belief that undermines health seeking behaviour, such as delivery in home” | |
| <ul style="list-style-type: none"> ● A systems approach is very important in the operation of any programme is the health care system, especially to improve services. The systems that require strengthening are the emergency responses system, communication and transport system, the supply chain system. The public health system also needs strengthening, as health starts in the community. “At an individual level, if certain things can be prevented in the community, then that also reduces the disease burden within the health care system. This is why I said we have certain systems such as SMAGs who are the link between the community and the health care system at the lower level in terms of primary healthcare.” ● However, the public health system is not very strong because, in some areas, the SMAGs are not very active while in others, they do not even exist; partly because there are few incentives. As a result, the health care system is negatively affected. Community leaders play a very big role in the health of the mothers within the communities where they live. | <p>Interview, MoH service provider. Lusaka, Zambia. August 2021.</p> |
| <ul style="list-style-type: none"> ● UNFPA has provided training for EmONC services for MoH facility staff. They have also trained tutors in the midwifery school to incorporate EmONC in their teaching. In this way, as the midwives graduate, they will have had EmONC skills. UNFPA has also provided equipment to address issues of EmONC and funds for supervision and mentorship. This enables staff to reach the facilities to supervise and mentor staff in those facilities. ● There are challenges to the delivery of quality health services in maternal health. There is need for infrastructure to ensure delivery of services is not disrupted; logistics for materials deliver quality health services (vaccines, preventive drugs, ITNs, stationery such as data collection, registers, tally sheets, etc.), human resources (skills, knowledge); and information to community members for creating demand for services. ● “There is also a need for mechanisms for feedback including informing us our deficiencies in providing services.” | <p>Interview, MoH staff. Western Province, Zambia. August 2021.</p> |
| <p>Revision of EmONC Training Package UNFPA, with UNICEF (with support from EU), WHO, CHAI, CIRZD and others, joined efforts to support the update of the EmONC Training Package in 2016. This version updated the original training package developed in 2007 and revised in 2009. This version includes a two-week course, with week one devoted to theory and demonstration and week two for skills acquisition and practicum in a clinical site, followed by four weeks of self-directed learning at the trainee’s work site and a structured five-year mentorship programme, 4-6 weeks later. Other updates included the non-pneumatic shock garment for</p> | <p>MoH, Zambia. EmONC Trainer’s Guide (Draft). 2016.</p> |

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| <p>shock management, uterine balloon tamponade (UBT) for postpartum haemorrhage, guide and checklist for administration of magnesium sulphate, Elimination of mother-to-child transmission (EMTCT), Option B+, management of HIV exposed infants and Post Exposure Prophylaxis.</p> | |
| <p>Training of service providers in EmONC (abridged course)</p> <ul style="list-style-type: none"> ● UNFPA supported the North-Western Provincial Health Office to conduct an abridged EmONC training course for 13 health care providers from facilities which had challenges in managing pregnant women who presented with complicated conditions. North-Western Province has been facing challenges with reducing maternal deaths for past five years; most common deaths were from postpartum haemorrhage and eclampsia. Although intended for 13 providers, a total of 86 health care providers from Kalumbila, Solwezi and Mufumbwe Districts benefitted from the activity. Findings include: <ul style="list-style-type: none"> ○ Majority of sites visited had the full range of recommended protocols for labour ward and antenatal clinics. ○ In nearly all facilities, infection prevention strategies were evident. ○ Rapid response mechanisms were in place to respond to emergencies, i.e., use of social media platforms (i.e., WhatsApp, call alerts for incoming referrals). ○ Evidence observed of well-coordinated team effort in most facilities despite not having adequate numbers of staff. ○ Despite country-wide shortage of magnesium sulphate and blood supply, most sites had a consistent supply of key commodities for service provision. ○ Majority of providers used partographs. ○ Although protocols and posters existed, providers were ignorant of content. | <p>Sasa, D. and Muna, L. Report on EmONC Mentorship conducted in Kalumbila, Mufunbwe and Solwezi Districts, North- Western Province. 2020.</p> |
| <p>MoH EmONC training</p> <ul style="list-style-type: none"> ● “Provision of Emergency Obstetric and Neonatal Care (EmONC) is one of the many interventions that the MoH has put in place to reduce deaths of women and their newborns from obstetric and neonatal complications. In order to achieve the goal of having less than 100 maternal deaths per 100,000 live births by 2021, the MoH through the Provincial Health Office has partnered with UNFPA in Solwezi to train midwives in basic EmONC. Fourteen (14) nurses, of which 12 were from Solwezi district, 1 from Mufumbwe district and 1 from Kabompo district were recruited for the training which was conducted from 18th to 27th November 2019. The mix of participants included Registered Nurses, Certified Midwives, Enrolled Nurse and Enrolled Midwives from different health facilities. Majority of these facilities were selected either because there were challenges in managing pregnant women identified in those facilities or due to their uniqueness with respect to distance to the next level hence requiring staff with additional skills to manage complicated cases.” p.1 ● The goals of the course were to: <ul style="list-style-type: none"> ○ Train participants to become skilled birth attendants. ○ To equip participants with skills to resuscitate neonates ○ To equip participants with basic checklists to ensure timely referral of complex cases to next level of care. ○ Other objectives were to foster teamwork and ensure good communications. ○ PAC and family planning was included in the EmONC training. | <p>MoH, Zambia. Report: EmONC Training, Solwezi General Hospital, North-Western Province. 2019.</p> |

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| <p>UNFPA support of mentorship and supervision to support quality of care</p> <ul style="list-style-type: none"> • Mentorship was conducted at Mushili RHC, Fwaka RHC and Kasanka Zonal facility by a team from Luapula Province and two mentors from Samfya District. The focus areas were: Helping Babies Breathe (HBB) and Helping Mothers Survive (HMS) following postpartum haemorrhage. These gaps had been identified from prior quarterly supervisory visits. The mentors identified gaps and supported actions to address them, e.g., supporting the in-charge to implement logistics to ensure that the PPH box is available (Mushili), supported infection prevention/daily cleaning of labour and postnatal room (Fwaka), and supporting management of PPH skills by a new RN deployed at the facility (Kasanka Zonal Facility). | <p>Kanswata, M and Chabi, CA. Report on Mentorship: MoH, Luapula Province, Zambia. 2019.</p> |
| <ul style="list-style-type: none"> • “MHTF has been catalytic for supporting mentorship programmes/supportive supervision programmes as well as provinces for support for integrated SRH. Quarterly MPDSR meetings are conducted for all the districts. Whenever there is a maternal death provinces support surveillance and teams that do reviews. Now we want to start the confidential inquiry. MHTF is supporting 2021.” • The programme supports mentorship for midwives in a number of areas, including FP, LARCs and also in the issue of leadership to encourage them to take a leadership role, since most are facility managers. There are trained mentors in EmONC, in family planning and also at provincial level, i.e., the Nursing Officer. Once a quarter UNFPA supports them to mentor midwives who have identified and experienced maternal deaths. | <p>Interview, UNFPA Zambia national staff. August 2021.</p> |
| <ul style="list-style-type: none"> • “EmONC functionality mentorship and monitoring visits continue to be conducted in UNFPA-supported provinces (North-Western, Luapula, and Western Provinces). Some of the identified gaps include lack of basic equipment and demand generation for timely maternity care. Plans to train SMAGs and procure equipment have been included in 2020 AWP for possible funding from MHTF and Core Funds. 25 midwives trained in HBB, and HMS by the Midwives Association were mentored in Luapula Province.” (p.2) | <p>UNFPA, Zambia. MHTF 2019 End of Year Annual Report. Undated.</p> |
| <ul style="list-style-type: none"> • UNFPA supported interventions aligned with the MoH goal of reducing maternal deaths and to achieve universal access to RMNCAH in Zambia. Mentorship was supported for 219 healthcare professionals from Western, North-Western and Luapula Provinces to increase the number of health facilities that offer BEmONC services, including CAC, neonatal resuscitation and provision of essential medicines. Thirty (30) midwives were mentored in the provision of CAC. Provision of signal functions remain a challenge in most EmONC facilities; Constant unavailability of blood products was identified as the main challenge in CEmONC facilities. | <p>UNFPA, Zambia. MHTF Annual Report, 2020. Undated.</p> |
| <p>Example of mentorship in province not supported by UNFPA</p> <ul style="list-style-type: none"> • JHPIEGO had a five-year project for integrated maternal, newborn and child health and family planning which came to an end in December 2020. It provided assistance at community-level and at facility-level. The lead partner was the Church Health Association of Zambia (CHAZ) with JHPIEGO as the sub (for facility inputs). CHAZ took care of community (SMAGs) who work with the women in the community, find the pregnant women and refer to health facility for early ANC booking danger signs in pregnancy and PNC follow-up. For those that were living in hard to reach areas, they ensured that they lodged at maternity homes. They also did some village banking to sustain efforts. At facility level, JHPIEGO built capacity for providers in EmONC and did mentorship and formed mentorship group teams in the district and supported them to conduct mentorship. Also did refocus the efforts of mentorship to zonal hubs. Zambia has zoned their health facilities and | <p>Interview, INGO national staff. Lusaka, Zambia. August 2021.</p> |

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| <p>we provided the models for simulations to assist in training and mentorship in various skills at zonal facilities for existing mentors at facilities. Provided mentorship to all other facilities. Also assisted in training in LARCs. On the community side, CHAZ trained CBDs for injectable. During EmONC, we trained providers in various skills (helping babies breathe, care for every baby, manual removal of the placenta, PPH management, management of pre-eclampsia. Strengthening referrals and use of the uterine ??? and the pneumatic shock garment. Project operated in 5 provinces: Luapula in selected districts (5 districts), Southern (5), Eastern (certain number, but because they created new districts), Lusaka (1 district, Muganwa).</p> <ul style="list-style-type: none"> ● UNFPA also worked in Luapula District. “They worked on those thematic areas, except not sure about midwifery. They have been supporting the MAZ (I am a member) to do some activities and conferences.” | |
| <p>Introduction of Safe Delivery App</p> <ul style="list-style-type: none"> ● UNFPA collaborated with the Maternity Foundation to support the MoH to introduce the Safe Delivery Application, an app that can be downloaded on any smart phone and used offline by midwives and doctors to support knowledge on the management of pregnancy-related complications. Twenty-five midwives and doctors were trained in its use with the intention to roll-out in 2020. | UNFPA, Zambia. 2019 Annual report. 2020. |
| Online survey | |
| <p>Question 17: Looking forward, how can UNFPA strengthen its contribution to MNH and SRHR in your country?</p> <ul style="list-style-type: none"> ● By engaging more on upstream activities on EmONC, MPDSR and quality of care. More work needs to be done on evidence generation, and there should be more flexibility to learn from other countries on key areas such as EmONC network. | Online survey conducted between May and July 2021 |
| Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC | |
| Indicators: | |
| <ul style="list-style-type: none"> ● Demonstrable improvements in health care provider capacity (as defined by the COM-B⁴ model of behaviour change) in the MHTF-supported facilities to deliver quality integrated SRHR services and MNH care in accordance with service standards and guidelines ● Trends in the proportion of functioning BEmONC and EmONC facilities within the national network ● Views of implementing partners (national health officials, NGOs, CSOs, community leaders and individuals) regarding effectiveness of capacity development efforts by UNFPA and how it has improved the performance of skilled birth attendants ● Alignment of UNFPA capacity development inputs with MHTF core principles (Equity in access, quality of care and accountability; plus, principles of human rights and gender equality). | |
| Observations | Sources of evidence |
| Global | |

⁴ The COM-B model of behaviour change (Mayne 2016) will be used to assess provider capacity based on three necessary conditions: 1) capability (necessary knowledge, skills, and attitudes to deliver quality care), 2) opportunity (having the necessary infrastructure, equipment, supplies and tools to deliver quality care), and 3) motivation (internal cognitive and emotional processes related to willingness and perceived personal benefit of providing good quality of services).

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| <ul style="list-style-type: none"> While the availability of services has become a less acute problem in many countries, the quality of care is an ongoing challenge in high-, middle-, and low-income countries. Finally, the launch of the SDGs entailed the development and revision of global MNH strategies and indicators; stakeholders now await EmONC handbook revisions in order to implement these strategies most efficiently and effectively. | <p>Columbia University and AMDD, Concept Note for Columbia University/Averting Maternal Death and Disability Program, 2019, University of Columbia, New York</p> |
| <p>Bangladesh</p> | |
| <ul style="list-style-type: none"> EmONC and midwifery: an action plan to address gaps in care being provided to women with PPH and eclampsia was developed and has been endorsed by the MOH&FW; this will support UNFPA future programming in dealing with obstetric emergencies. | <p>UNFPA, 2018 Midyear Progress Report, 2019, p.2</p> |
| <ul style="list-style-type: none"> UNFPA e-learning modules covering all key obstetric emergencies were rolled out in Bangladesh in 2019 in collaboration with the Directorate General of Nursing and Midwifery. A total of 39 midwifery faculties from all 38 nursing and midwifery institutes and colleges in Bangladesh completed nine modules and are now deploying these in midwifery schools nationwide. Participants were given childbirth videos on childbirth and essential newborn care, such as on managing the second and third stages of labour, and infection prevention, that were developed by the Global Health Media Project. | <p>The MHTF UNFPA, Annual Report 2019, 2020, p.31</p> |
| <p>Benin</p> | |
| <p>Lessons learned:</p> <ul style="list-style-type: none"> Midwives are essential for EmONCs. The standard adopted in Benin is four midwives for a basic EmONC health facility. Monitoring of EmONC health facilities must take into account at least the three following indicators: the needs for midwives, the number of functional EmONC health facilities and the link between BEmONC and CEmONC. The reinforcement of the skills of midwives for the management of BEmONCs is carried out through: <ul style="list-style-type: none"> Improving initial training focused on respectful care, safe deliveries and BEmONC The accreditation of internship locations (clinical and educational) The deployment of competent midwives as a priority in the BEmONC. <p>Next steps:</p> <ol style="list-style-type: none"> Preparation of the technical report of the three workshops National workshop for restoring the prioritization of EmONC health facilities: (i) presentation of results, (ii) validation of the EmONC map and issuance of a ministerial order Translation of the targets defined during the workshops into the annual operational plans of the health departments Monitoring of network activities and use of the results for the development of bottom-up responses based on local expertise Establishment of a similar approach for the peripheral maternity network and the community. | <p>Mission Report: Third workshop for the prioritisation of EmONC Facilities Alibori, Atacora, Borgou and Donga Districts, Benin, 3 December 2018</p> |
| <p>Challenge: Mass of work</p> <p>The mass of work is a problem; we are tired.... For example, 9 deliveries in 1 day + 30 visits. 24h shifts should not be done - it should be 12 hrs only. The problem is that the government does not want to recruit.</p> | <p>Interview, Midwife in a public sector health facility, Benin, June 2021</p> |

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| Impact of the attitude of midwives on women in the clinic <ul style="list-style-type: none"> • I can say that the midwife who is there works well. When she receives you, she asks you questions, and she looks at you. • Despite our complaints though, they have not yet received us. I'm telling you there is a lady over there writhing in pain. Normally the midwives should leave everything in order to take care of her. Instead, they just sit there chatting with each other. It's not good. • If I have to say my experience, I left home early this morning with a motorcycle taxi. I paid 800. I knew I was going to be back soon to take care of my business, but I am still here. And if I do not go back quickly, I will not have a sale for the day. • There is even a lady who has a backache and is in pain. ... We were all there since this morning. The problem is, there are not even many of us. There are only 13 of us but we have been here since morning. | Focus group discussion, ANC patients, Benin, June 2021 |
| Sudan | |
| <ul style="list-style-type: none"> • Quality improvement is needed. "The concept of respectful maternity care is completely absent." | Webinar presentation, FMOH, Khartoum, 17 June 2021 |
| A critical gap <ul style="list-style-type: none"> • Staff shortages and personnel availability and capacity are the most important areas of shortfall • Main resources are in Khartoum but even there, MNH services are limited because of insufficient health staff • Need retention mechanisms as the salaries are too low. • A while ago, low salaries were still acceptable. For example, UNFPA retention for a midwifery tutor was only USD 55 per month. Now though, with inflation and everything that has happened, this is insufficient to attract/ retain skills. • Health workers now look for best offers in the private sector, and there is more migration especially to the Middle East. | Interview, Research/practitioner, Khartoum, Sudan, 15 June 2021 |
| <ul style="list-style-type: none"> • Most functioning EmONC health facilities face major shortfalls in quality of care, however. Closer monitoring will help the MoH to address these issues, including unnecessary surgical interventions such as caesarean sections. | UNFPA, MHTF 2019 Annual Report, Sudan. Khartoum, 2020 |
| Main challenges facing MNH service provision in Blue Nile State <ul style="list-style-type: none"> • Neonatal care capacity building for health providers including doctors and nurses • Rehabilitation of the health facilities, especially the building whose condition worsens during rainy season • Need more training, recruitment and retention of the midwives due to high turnover rate. • Referral of cases. The hospital has no functioning ambulance. | Interview, SMOH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| UNFPA support to strengthen midwifery skills across EmONC <ul style="list-style-type: none"> • The EmONC network has become an important resource and means to target additional training capacity • For example, using the national protocol, UNFPA supported an advocacy programme (communications) to help midwives perform safe deliveries for COVID-19 affected patients focusing in EmONC facilities. | Interview, RH Team, FMOH, Khartoum, Sudan, 1 June 2021 |
| FMOH capacity building <ul style="list-style-type: none"> • In-service training and pre-service training for midwives has been largely stopped as of 2021 and indeed pre-service training of community midwives was stopped in 2018. The midwifery focal point identified that the FMOH is now working on the technical and teaching manuals and is yet to start with training. | Interview, RH Team, FMOH, Khartoum, Sudan, 1 June 2021 |

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| <ul style="list-style-type: none"> ● At health facility level: 66,845 deliveries were performed in health facilities supported by UNFPA; 59 BEmONC and 49 CEmONC facilities received medical equipment and supplies; 8,900 pregnant women benefitted from lifesaving medical supplies; 65 EmONC facilities received PPEs; supported the referral services through maintenance of 18 ambulances; deployment of temporary ambulances in Khartoum state during COVID-19 lockdown; establishment of 23 community based referral groups; reimbursement of transportation cost in three states. | <p>UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, Khartoum, Sudan</p> |
| <p>Assessment of needs at EmONC sites</p> <ul style="list-style-type: none"> ● EMONC training refers to the training of the teams that will conduct the first-round monitoring. ● FMOH teams trained to assess needs at the EmONC facilities including among staff (capacity, skills) ● The content of the training is quality improvement and control for the EmONC selected sites/facilities, and EMONC standards and norms. ● The first main training was during 2020 and due to COVID-19 “we were not able to proceed to the state level monitoring, prioritisation, and finalisation of the response plans”. ● It is a prerequisite for the monitoring mission to strengthen the capacity of the monitoring teams on the monitoring tools. | <p>Interview, UNFPA CO, Khartoum, Sudan 23 June 2021</p> |
| <ul style="list-style-type: none"> ● Two BEmONC health facilities are expected to refer to a CEmONC health facility in another State. In terms of human resources, there are only graduate nurse midwife and nurse midwives in the Damazin Maternity Hospital. ● Most designated health facilities have a doctor, with Damazin having 12 doctors and 3 Ob/Gyn. Elmidin 10 is the only health facility without any doctor. There is an important gap of 14 midwives to be filled-in in the short/medium term in order to ensure the provision of services 24/7. ● Other major gaps identified by the working group are the absence of anaesthetists and neonatologists in the major hospital (Damazin) and the absence of anaesthetists and OBGYN in the Boutt Hospital. In terms of infrastructure and equipment, the Damazin hospital has a functioning laboratory for advanced tests and three other hospitals have a functioning laboratory for basic tests (Aggdi Centre, Bidoos Hospital, Boutt Hospital). | <p>FMOH and UNFPA, EmONC Prioritization Technical report: State Level Analysis, 2017-18, Khartoum, Sudan</p> |
| <p>UNFPA supports FMOH identified priority activities</p> <ul style="list-style-type: none"> ● Contribute to the implementation of the costed EmONC work plan to cover the gaps of the prioritized health facilities. This includes procurement of equipment and capacity building of EmONC staff. ● Capacity building for 11 EmONC facilities staff on IPC in two states was conducted, the rest of the budget will be utilized in semester two to cover the identified gaps in EmONC facilities after finalizing the EmONC network. ● Support the ministries of health at national and states levels to monitor the network of EmONC facilities (including monitoring of the deployment of skilled staff, MNH data using the agreed upon indicators and referral links). ● The HQ and FMOH are working on finalizing the prioritization report. The monitoring visits were planned to be implemented in late 2020 using the third tranche of MHTF funds. However, COVID-19 affected progress. | <p>UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan</p> |
| <ul style="list-style-type: none"> ● Activity: Support implementation of community-based referral mechanisms to improve referral to EmONC facilities and address financial barriers to access EmONC services The preparatory exercise is done, targeting 28 EmONC facilities in seven states. | <p>UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan</p> |

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| <ul style="list-style-type: none"> • Problem in Sudan relates to a preference for home births that persists. The quality of care and a functional EmONC network can help shift attitudes over time, but this is a bigger problem. The EmONC network investment programme is about improving health outcomes and results for women already in the care of the health facility. Most deaths happen because of a failure to provide care at primary level and a failure to refer. Another line of investment is around strengthening family planning to incentivising women, educating women, and empowering women. | Webinar presentation, FMOH, Khartoum, 17 June 2021 |
| <ul style="list-style-type: none"> • A lot of money has been invested in capacity building programmes: most health providers are well trained. And there is a high demand for services from well-trained health providers. But there is not enough investment in infrastructure (leaking roof) and consumables (medicines) and equipment repair (baby warmer not working). | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |
| Togo | |
| <ul style="list-style-type: none"> • While 100 per cent of CEmONC maternities are open 24 hours a day, 7 days a week, only 50 per cent of them meet the standard of three midwives to make them functional 24/7. Advocacy is being done with the MoH for the increase in the number of midwives in EmONC facilities, in conjunction with the Association of Midwives. The CO intends to strengthen and continue this advocacy through the advocacy document developed for the recruitment of unemployed midwives. | UNFPA, MHTF Request Proposal 2019-2022, 2019, p.4 |
| <p>Challenges to quality of care by trained staff</p> <p>The presence of well-trained staff working as a team helps reduce deficits in signal functions. Thirty-five per cent of maternity hospitals in the network still have deficits in performing all signal functions, in particular for the use of aspirators, the administration of magnesium sulphate and the management of neonatal resuscitation and the availability of blood products.</p> | UNFPA, Mapping the prioritisation of EmONC in Togo, 2018 |
| <p>UNFPA focus on Midwifery in EmONC</p> <ul style="list-style-type: none"> • Thanks to the French MUSKOKA Funds, UNFPA, WHO and UNICEF are supporting the implementation of the integrated strategic plan for maternal, newborn, child and adolescent health, in particular in the field of EmONC and MPDSR, two interventions in which the UNFPA MHTF fund plays a catalytic role, making the UNFPA Office the lead in Togo on the issue of EmONC and its implementation. • Togo is a model in the sub-region despite the still unsatisfactory results. The MHTF fund provides significant support in the promotion of midwifery practice. The progress underway relates, among other things, to the integration of EmONC into the maternal and neonatal health plan with a developed programmatic framework: <ul style="list-style-type: none"> ○ the refined 2018 EmONC network, regular monitoring which analyses the situation and provides data on the availability and quality of care, and which supports the MPDSR, the regular range of challenges in the health care system and causes of maternal deaths ○ an effort to integrate the health package, the overhaul of the training curricula for midwives, to adapt to ICM and WHO standards, the strengthening of the skills of instructors for the supervision of students, not to mention the ongoing efforts to improve their basic qualification (training at master's level) ○ the definition of a new framework for midwifery practice in Togo which is in progress | UNFPA, MHTF Request Proposal 2019-2022, 2019 |
| Uganda | |

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Strengthening capacity at tertiary level

- Kawempe National Referral Hospital is a tertiary hospital in Kampala, serving a population of 4.5 million people. Annually there are 30,000 deliveries at the hospital and an average of 80-100 babies born daily. The tertiary neonatal unit has 81 beds and is organized into four compartments, namely: Intensive care unit with 10 beds, high care area with 20 beds, and stable ward with 50 beds for pre-terms and term babies.
- UNFPA supported a consultancy to **improve newborn care through the development of a QI plan**. The following activities were undertaken:
 - A **quality assessment** of services covered in the neonatal intensive care unit (NICU), including gaps in skills and knowledge among health workers
 - Compile and orient staff on protocols and management guidelines for common conditions
 - Develop a **QI plan**
 - Guide the NICU team to reorganize the NICU for better patient flow and service delivery
 - Conduct **drill sessions and mentorship** on key critical emergency interventions for the NICU team.
- Key challenges identified in the inception report included:
 - While the infrastructure and basic equipment are available, the **patient numbers are very high**. For example, there are two babies per incubator, increasing risk of infection. Equipment exists (ventilators, CPAPS, oxygen ports, monitors and radiant warmers), but not in relation to the numbers of patients.
 - There are **not enough nurses and doctors** available relative to the number of patients.
 - **Protocol books are available, but not displayed nor uniformly used**. There is a need to harmonize and train staff on use of protocols to standardize care. Skills need improvement for “management of respiratory distress from delivery room to Neonatal intensive care unit, neonatal resuscitation, feeds and fluid management, infection control and antibiotic stewardship, neonatal ventilation and surfactant administration.” (p.15)
 - There is also the **need to “functionalize the lower health units** to reduce referrals to Kawempe so as to decrease the burden of sick newborns admitted there.” (p.18)

V. Nakibuuka, Inception Report, Kawempe National Referral Hospital, Uganda, 2020

- UNFPA has supported the renovation of the neonatal special care unit at the Kawempe national referral hospital (together with UMTN (mobile network), UNICEF and several other partners. **UNFPA contributed both technically and financially, mainly with remodelling and equipment.**
- For maternal health, UNFPA also procured delivery beds, operating beds and a repair bed (the latter still has not been delivered), which helped improve EMONC services according to the interviewee.
- Kawempe national referral hospital has serious HRH gaps, including lack of midwives and anaesthetists, and request UNFPA for support in this area. “We ask UNFPA to continue supporting the process of decongesting Kawempe and in printing our CEmONC protocols, tools, etc. Our HR is not adequate in numbers and if they can cover the gap for 1-2 years until the government has recruited. In Mulago, I saw 30 midwives and nurses; but at Kawempe we need 50 as we have a high turnover of patients. There is no revenue collection, no increase in wage, we cannot recruit anymore, got worse with COVID-19. We had been given green light for review of staffing structure, to understand which critical cadres we needed, and we did that –

Interview, MoH service provider, Kampala, May 2021

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it was prior to COVID-19 – but as we were midway in the process, we were informed that there was no wage to take on these new cadres, so everything was put on hold. It was probably because of low revenue collection due to the total lock of our country.”

MoH perspectives on gaps and challenges in EmONC and MNH

- Largely there is a **skills gap among health workers**. UNFPA support is appreciated, especially to address the gap in update of long-acting reversible contraception (LARCs). “We really undertake a rights-based approach with family planning. We are not promoting some methods over others. So, with UNFPA we have done methods-mix training of the health centre worker (HCW).”
- With ANC, there is **late attendance with many women foregoing ANC visit** during the first trimester. There have been some studies undertaken, not only by UNFPA but also other agencies like USAID. “We see about 20 per cent for the first ANC in first trimester. For the fourth ANC, it is also less than 50 per cent but there have been some improvements over the years. Slow progress.”
- Regarding labour and delivery, **many mothers and babies are lost due to PPH, close to 50 per cent of maternal deaths** in the country. **A lot of support from UNFPA has been around building skills of health workers in EmONC**, but PPH remains an issue. The largest gap was the skills, but next in the line are issues of equipment, especially at the high-level facilities.
- In addition to skills and equipment gaps, the other issue is demand creation at the community. “If we are only addressing the supply side, where we are already doing a lot and a lot of services are already available, what about demand and access, and then we have COVID-19.”
- There is low uptake of PNC services. **There are few entries when the PNC registries are looked at**. Sometimes the health worker does not pay a lot of attention to the women who come for PNC, especially those who have no complaints.
- The **last key issue is inadequate HRH**, especially the critical cadres, i.e., anaesthesia officers and the medical officers. “We have issues with our staffing norms. A facility that needs four doctors, will still only provide two doctors, based on staffing norms 20 years ago. MoH is currently revising staffing norms because the population of Uganda has almost tripled since the norms were developed. A facility has maybe only two medical officers according to staffing norms – but they really need four to five. So even if it says “all positions filled” – it means in reality that it is not filled; it is still a gap of three. They have begun with the revision of staffing norms – starting at the regional referral hospital (RRH). The RRHs are overwhelmed with very many clients, but the staffing is so thin. We hope that at the end of this process, we will have more health workers, especially the critical cadres, provided for within health facility structures.”
- **Commodities remains an issue**, although the MoH is appreciative of the support from UNFPA and USAID, and UNICEF for child health medicines.
- For the newborn, the equipment and supplies are an issue for newborn resuscitation/HBB. Many facilities lack ambu bags, and masks are not available in most places. “We have so many HC III, but often we give equipment etc. to HC VI and hospitals, partners have tendency to focus on high volume facilities – especially those who are focusing on numbers/targets – e.g., USAID. But many HC III conduct many, many deliveries – but partners focus on high volume. But we still need the

Interview, MoH official, Kampala, May 2021

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| <p>Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC</p> | |
| <p>equipment at all HC III – there are more than 2000 HC III. They say, “look for 20 per cent of facilities who give you 80 per cent results.”</p> <ul style="list-style-type: none"> There is a need to continue and strengthen capacity building, through on-site mentorships, as opposed to classroom teaching, to ensure that a critical mass of health care workers receives targeted MPDSR, EMONC, adolescent SRHR and GBV. “We have also had district-based learning sessions on SRHR and GBV, where low and high performing districts come together to review, discuss and compare. UNFPA supports training of health care workers in family planning and method-mix for GBV survivor. For as much as we have been doing method mix training – but the gaps are in LARCs. The insertion of IUD is a key gap – much of our practicum was focusing on the IUD insertion – both postpartum and interval/general IUDs. The funding was more for GBV aspects, but we (MoH together with UNFPA) made it more comprehensive – we used Sida funding (through UNFPA) for the trainings on method mix including EMERGENCY funding – specially targeting GBV survivors – but also other women are coming to the health facilities and will benefit from the improved family planning services.” | |
| <p>Challenges/gaps in EmONC (HC IV) and BEmONC (HC III) facilities:</p> <ul style="list-style-type: none"> “There are still gaps in functionalizing level four health facilities to address emergency obstetric complications as well conduct caesarean sections and reduce on the referral burden to the regional and referral hospitals since this requires a concerted effort from different sectors including water and energy. The CO continues to invest in capacity building through training and mentorship of human resources in EmONC and quality improvement as well as providing equipment where possible.” | <p>UNFPA Uganda, Final Report for MHTF, 2020, p.20</p> |
| <ul style="list-style-type: none"> “Facility-based deliveries have been used as a proxy for skilled birth attendance. The assumption for the use of the proportion of health facility deliveries as a proxy for skilled birth attendance is that the birth attendants at health facilities have the necessary competent skills to provide care during childbirth and are trained, accredited and skilled health professionals (such as midwives, clinical officers, doctors, or nurses).(p.137) The skilled health professional must also be supported by appropriate standards of practice (education, training and regulation), and operates within an enabling environment (a functioning health system, comprising six building blocks). The proportion of facility-based deliveries improved from 47 per cent in 2016 to 58 per cent in 2019 in UNFPA-supported districts, which indicated that mothers were continuing to come to health facilities to deliver. However, the quality of obstetric care might have been below the expected standard, given that the proportion of health facilities in the target districts which were able to offer all the signal functions of EmONC was 8 per cent for HC IIIs and 7 per cent for HC IVs and hospitals compared to the targets of 70 per cent of HC IIIs, 60 per cent of HC IVs and 100 per cent of hospitals. As afore mentioned, the critical factors undermining the ability of health facilities to offer all signal functions of the EmONC were inadequate staffing level of critical cadres, inadequate provision of the basic amenities and infrastructure.” | <p>UNFPA Uganda, GoU/UNFPA 8th Country Programme 2016-2020 Evaluation Report, 2020</p> |
| <ul style="list-style-type: none"> UNFPA has focused on EmONC, ambulance/referral systems, and supporting and deploying midwives in hard-to-reach areas. UNFPA has also taken the lead on MPDSR (together with WHO). The key issues and gaps influencing MNH in Uganda are low health-seeking behaviours, lack of quantity and quality of skilled staff (including surgical skills and anaesthetists), poor logistics and supply chain management system, affecting availability of drugs and commodities including blood, lack of | <p>Interview, MoH national staff, Kampala, May 2021</p> |

Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC

equipment and ambulances/effective referral system. Most health facilities do not have the equipment to take care of premature babies

- **Only 60 per cent of mothers attend all four ANC visits.** For at least one visit (not first trimester), the percentage is high, at 98 per cent. The mortality is still high – in intrapartum care – is classically high. Seventy-three per cent of women deliver in health facilities, but there is the issue of delay in reaching the health facility, sometimes because of infrastructure, sometimes due to distance.
- “Still at community level, we have myths and misconceptions, **and people preferring using traditional birth attendance.** They are at near reach, but they sometimes also feel, that they may not get so much from the health facility – it may not be any different than delivering with their traditional birth attendants.
- **They complain about lack of staff at the health facilities,** and the environments at the health facilities, e.g., there are lack of medicines, and when they are asked to buy medicines themselves, they think, why go there, if I have to pay for these drugs anyway? We had issues with bad attitudes of providers towards women delivering, bad treatment, but I see that reducing (improvement).
- We have a **call centre here at MoH** where people can report about those “not very nice experiences”, and that is how we get those reports. Sometimes, also, they do not find a midwife, so next time, they will not try to go there.”
- In terms of the EmONC signal functions: Only 71 per cent of CEmONC sites perform caesarean sections due to lack of skills and/or infrastructure/equipment. According to the guidelines, midwives are not allowed to perform “assisted deliveries” although it is one of the key BEmONC functions supposed to be performed at every HC III (and there is no medical doctor at HC III).
- In the national standards for EmONC, “assisted delivery” is a key signal function, including at HCIII facilities (i.e., BEmONC sites). But the **health worker (midwife) who is at HC III is not mandated by their scope of practice to do assisted delivery.** There is no medical officer/doctor at HC III. Maybe a manual extraction can be managed at that level (HC III), but they have to refer to the next level HCVI for assisted delivery. It is a policy issue. This means that in any HCIII (BEmONC site), they can only perform four out of the five basic signal functions.

- **UNFPA is making a significant contribution to ensuring the functionality of BEmONC and CEmONC facilities** in the sub-region by supporting equipment, recruitment and training.
- UNFPA supports **strategies to increase referrals and access for refugee and host communities,** including ambulance services, demand creation, pregnancy mapping and vouchers (i.e., identifying pregnant girls and women and referring them to the health facilities).
- UNFPA supports the MPDSR process by **providing funds and technical assistance** to strengthen functionality of the MPDSR committees at facility and district level. While support for HR/equipment/ambulances seems to have been going on for a while, the MPDSR, vouchers and EMONC training seem to have started only in 2020, as the large new ANSWER/Netherland programme was launched.

Interview, UNFPA national staff, Uganda, May 2021

Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC

Facility staff perspectives on challenges/gaps in MNH service delivery

- Facility level staff noted there are only two midwives and a nurse trained in BEmONC to work in ANC, family planning, labour and delivery, exposed infant diagnosis, and young child clinic/ immunizations across the MCH department.
- The **referral system is challenged**: Some mothers decline to be referred because they do not have relatives where they would be going. **Transport home is an issue**. The ambulance will take them, but they have to use their own means to return home.
- Gaps at the facility include: the theatre is not functional and there is no ultrasound machine (need to refer to the main hospital in Kigtum centre; but only 3 or 4 out of 10 women will go). “So, we end up misdiagnosing, because we recently had undiagnosed twins – it happens once in a while - it is only when they come into labour that we realise.”

**Interview, MoH service providers,
Lawmo District, Uganda, May
2021**

Service capacity-building efforts (non-MHTF funded)

- Marie Stopes-Uganda receives support from UNFPA via the Netherlands-funded ANSWER project, starting in late 2020 for capacity building in EmONC and MPDSR and demand-generation/access activities (via pregnancy mapping and a voucher programme for adolescents) in the West Nile and Acholi Sub-Region (Lamwo District is in Acholi).
- **A competency assessment for midwives was conducted to assess level of knowledge and skills in EmONC**. Subsequently, EmONC training and mentorship were started in late 2020.
- The assessment also identified gaps in equipment and materials which were communicated to UNFPA (as MSU does not have a budget for equipment/materials, and it can be covered by other funding sources, e.g., Japanese and Emergency funds).
- “That is how we started training for all 14 districts targeted by ANSWER including Lamwo district. The competence assessment was general, but we had interest in EmONC services. We used the MoH assessment tools, but incorporated additional questions, after consultation with the MoH because we were interested in assessing the knowledge and skills for providers. They allowed us to use our (Marie Stopes) competency tool as well, as the MoH tools were too broad. Our assessment tool is more focused and we assessed: ANC, PPH, infection prevention, newborn resuscitation, hypertensive disorders in pregnancy, family planning LARC methods (PP-IUD).”
- The MSU coordinator indicated that they integrate family planning messages and services in EmONC training: **“We cannot do EmONC without doing family planning, for example, post-partum family planning (PPFP)”**.
- MSU makes efforts to strengthen the institutional sustainability of the interventions, e.g., by selecting two (senior) district health care providers to become the lead mentors, i.e., responsible for supervision, mentorship of facilities etc. When the project ends, these two mentors will have the capacity to continue to lead the mentoring and supervision in the district. Three weeks after the training, **MSU conducted on-site mentorship by the trainers who are national trainers/mentors from MoH**. Before training, MSU asked the districts to identify two district trainers to support trainings and mentorship for the purpose of sustainability. “Because projects come and go – and we want to build district capacity which can remain even when we leave again.”

**Interview, NGO national staff,
Arua District, Uganda, May 2021**

Area of Investigation 3: Maternal and perinatal death surveillance and response

Evaluation Question 3: To what extent has the MHTF contributed to firmly establish the main components of the MPDSR programme (guidelines and tools, mandatory notification, costed national plan); to support its implementation at national scale; and to increase the notifications of maternal deaths and strengthen the quality of maternal death reviews and implementation of the “response” component?

Sub-questions:

- a) How, where and to what extent has the MHTF contributed to the establishment and scale-up of MPDSR?
- b) To what extent has MHTF support contributed to sustained or increased quality and credibility of MPDSR as evidenced by increased notification of maternal deaths among other features?
- c) Where and how has MHTF contributed to service and systems improvements because of MPDSR findings?

| Evaluation criteria | <i>Relevance, effectiveness, sustainability</i> |
|---------------------|--|
| Rationale | <p>MPDSR efforts intensified globally following the publication of technical guidance by WHO in 2013. By 2015, over 76 countries adopted policies for the systematic review of maternal deaths, and 41 and 56 countries have adopted policies for review of stillbirths and neonatal deaths, respectively. Since then, WHO and UNFPA have monitored progress in MPDSR implementation. They noted substantial gaps between adopting national MPDSR policies, setting up national and subnational review committees and monitoring other aspects of implementation. Quality of reviews varies within and between countries. MPDSR methodology requires comprehensive investigation of causes, circumstances, and preventability of each maternal death identified and a no-blame atmosphere is essential to pinpoint and make policy and operational changes that would improve quality of care. UNFPA supports countries to develop MPDSR with tracking indicators that are clear and measurable, and methods for analyses that best assess quality of death reviews and can track the impact of death reviews on health service quality. Strengthening MPDSRs is supported by the MHTF as a vital mechanism to build sustainable systems strengthening for better MNH and is linked to the EmONC response.</p> |

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive

Indicators:

- Alignment between global and regional evidence-based guidance and national strategies for establishing and operating a MPDSR process.
- Examples of UNFPA advocacy and policy dialogue in support of national plans designed to strengthen and scale up MPDSR.
- Strengthened coordination and capacity including increasing number of timely, complete death audits
- MHTF workplans include application of lessons learned (knowledge management) to improve quality and support scale-up of MPDSR within countries and to new countries.
- Number of MPDSR components that are implemented (out of four).
- Examples of investment by health authorities and partner institutions at global, national, and sub-national level with a focus on the relevance, effectiveness, and sustainability of MPDSR process and relevant follow up.
- Health authorities and partner institutions regard MHTF leadership on core principles of equity in access, quality of care, accountability, and on principles related to human rights and gender equality as a critical underpinning of the MPDSR approach.

| Observations | Sources of evidence |
|--------------|---------------------|
| Global | |

| Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive | |
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| <ul style="list-style-type: none"> ● Effective implementation and use of MPDSR in Africa varies significantly by countries. Also, most countries are facing challenges in: transitioning from MDSR to MPDSR; implementing community based MPDSR, especially identification of maternal and perinatal deaths at community level; integrating MPDSR with Integrated Diseases Surveillance and Response processes for timely notification and reporting of maternal and neonatal deaths; making MPDSR committees fully functional; legal and ethical issues around MPDSR; quality and timeliness of maternal and perinatal deaths reviews; preparation and dissemination of MPDSR reports, and timely implementation of recommendations of the MPDSR reports; and, creating MPDSR centres of excellence. The proposed workshop will provide a forum for countries to learn from each other; share tested tools and guidelines; and get updates from global and regional experts. The first two days of the workshop will focus on MPDSR data analysis and report preparation. The last three days of the workshop will focus on sharing lessons on effective implementation and use of MPDSR. | <p>UNICEF, WHO, UNFPA, Maternal Perinatal Death Surveillance and Response Capacity Building: Joint WHO/UNFPA/UNICEF Workshop - Concept Note, 2018, UNICEF, Johannesburg, South Africa</p> |
| <ul style="list-style-type: none"> ● The average maternal review rate (proportion of expected maternal deaths reviewed) increased from 7 per cent in 2015 to 17 per cent in 2019. However, most countries remain below the 40 per cent threshold for review, and maternal deaths in communities are usually not considered. ● These indicators reveal capacity gaps in analysing maternal mortality trends in MPDSR reports. They also reflect weaknesses in community health programmes in terms of MPDSR and MNH. ● The MHTF will continue to track improvements in MPDSR analysis and reporting, and guide programme managers. Greater collaboration and better financial coordination are important components. ● MPDSR programmes continue to face a variety of well-known obstacles, including a culture of blame, fear of retribution, a lack of skilled staff, stand-alone management and inadequate funds for implementing maternal review recommendations. | <p>The MHTF UNFPA, Annual Report 2019, 2020, New York, 2020</p> |
| <ul style="list-style-type: none"> ● What works in countries to strengthen community identification of maternal death is policy support and political leadership ● Countries that have detailed guidance on community identification of maternal death in the national guidelines have shown progressive improvement in identification of maternal death in the community. ● However, most national MPDSR guidelines have not yet integrated community identification of maternal death. For example, Ethiopia, Uganda, and Malawi mentioned about community maternal death notification, whereas Tanzania (Mainland) and Zanzibar only mentioned about community death notification in the objective but lacked details. ● Countries that have shown progress on community identification of maternal death has a strong leadership of the MoH. This is indicated by assigning a focal person for MPDSR responsible for supporting institutional development. | <p>UNICEF, WHO, UNFPA, Maternal Perinatal Death Surveillance and Response Capacity Building: Joint WHO/UNFPA/UNICEF Workshop - Case studies, 2018</p> |
| Regional | |
| <p>Regional support for MPDSR</p> <ul style="list-style-type: none"> ● In 2020, the East and Southern Africa joint UN team organized a series of virtual trainings for interested countries to support the strengthening of MPDSR systems, supported by the 2Gether4SRH Sweden emergency grant for continuing essential SRHR services during COVID-19. This is a six-month activity that entails two weekly virtual trainings to strengthen capacity to 1) identify and report all maternal and perinatal deaths, 2) correctly assign and code maternal and perinatal deaths, and 3) analyse maternal and perinatal death data. | <p>UNFPA, ESARO. Strengthening the availability, quality and reporting of maternal and perinatal death and cause-of-death data in national health information systems through enhancing the performance and quality of</p> |

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive

- Inception meeting was held on 30 November 2020 and included MPDSR focal points from WHO, UNICEF, UNFPA and MoH for the first phase countries.

existing MPDSR systems in first phase ESA Countries (draft), 2020.

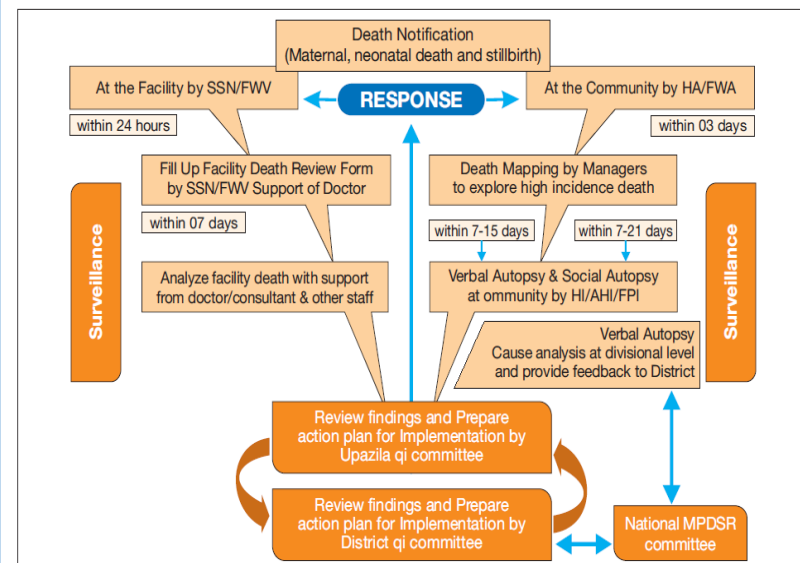
Bangladesh

- Considering the need of MPDSR in urban settings, Dhaka north city corporation **organized two workshops in the City Corporation on MPDSR to build the capacity of health managers** working in the government and private facilities located in the Dhaka North City corporation. The workshop was funded by UNICEF, and UNFPA provided technical support. Over 60 health managers were oriented on MPDSR national programme, and a brief on facility death review for maternal and perinatal deaths in the urban facilities was given during the session.
- Maternal and Perinatal Death Review (MPDR) after its pilot in 2010 in Thakurgoan in the existing health system by DGHS with support from UNICEF, UNFPA and WHO has made a surprising response in the health system and community that improved the availability and quality of maternal and neonatal health services. So the Government scaled it up to 14 districts by 2015. **The country has now adopted the global MDSR model developed by WHO for preparing death review system for Bangladesh.** Therefore, MPDR has been renamed as MPDSR after the WHO nomenclature.
- Government scaled up to 22 districts by 2017 and the **ultimate plan is to achieve countrywide scale up**, in all 64 districts. By the end of 2019, MoHFW has completed MPDSR scale up in 46 districts with technical support from UNFPA, UNICEF, WHO and other development and implementation partners.

UNFPA et al. MPDSR in Bangladesh - Progress and Highlights in 2019, 2019, p.26

UNFPA et al. MPDSR in Bangladesh - Progress and Highlights in 2019, 2019, p.5

UNFPA et al. MPDSR in Bangladesh - Progress and Highlights in 2019, 2019, p.6



UNFPA et al. MPDSR in Bangladesh - Progress and Highlights in 2019, 2019, p.7

- Provide **technical and financial support to organize MPDSR analysis meetings at the divisional level to identify probable causes of maternal and perinatal deaths.** 250 maternal deaths in the target districts will be reviewed in 2022. UNFPA supported to build the capacity of health care providers on MPDSR in six districts (Sylhet, Sunamganj, Moulvibazar, Habiganj,

UNFPA, Bangladesh MHTF Progress report, 2020, p.5

| Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive | |
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| Bandarban, and Noakhali) in 2020. Presently MPDSR is being implemented in 18 districts, supported by UNFPA. In 2020, 262 deaths underwent verbal autopsy and the cause of each death and a cause analysis workshop in Sylhet division assigned causes of maternal deaths from verbal autopsies forms. | |
| <ul style="list-style-type: none"> Output 11: Strengthen capacity for improving the quality of maternal deaths reviews and implementation of responses; Achieved Output 12: Strengthen reporting and operational research of implementation of M(P)DSR programme via processes and results on notification, review and response; Achieved | UNFPA, 2019 Annual Report MHTF Bangladesh, 2020, p.4 |
| <ul style="list-style-type: none"> MPDSR: Technical support provided to analyse the cause of maternal and perinatal deaths has been found to be effective to enable the cause of death to be assigned to cases. MPDSR has been found to be an evidence-based tool which has subsequently proven useful in advocacy efforts to support the development of 'The Maternal Health Protection Act' in Bangladesh. | UNFPA, Annual Report 2019 - Bangladesh, 2020, p.13 |
| Benin | |
| <ul style="list-style-type: none"> La Surveillance des Décès Maternels/néonataux et Riposte est [...] recommandée par l'Organisation Mondiale de la Santé (OMS) depuis 2004 et institutionnalisée au Bénin dès 2013. Après huit années de mise en œuvre de la SDMR au Bénin, les indicateurs de la mortalité maternelle et néonatale stagnent malgré de nombreux efforts consentis à divers niveaux. | Réunion statutaire du comité national SDMR pour évaluation de son fonctionnement, Septembre 2020 |
| <ul style="list-style-type: none"> Le concept des audits existe au Bénin depuis 1989 et la conduite d'études préliminaires, avec l'implication de la LSHTM, tel d'un doctorat sur les « near-miss », suivie d'une étude de faisabilité et la formation des comités 2013 : SDMR institutionnalisée au Bénin grâce à l'OMS UNFPA a commencé en 2015, sur la base de plusieurs volets : Notification communautaire, investissement des centres santé, travail sur l'audit et la riposte 2017 – UNFPA : Première analyse de mise en œuvre de SDMR au niveau national ; et depuis, chaque année, évaluation. Le rapport annuel récapitule toutes les activités relatives à la notification des DM et DN, la réalisation des audits et la mise en œuvre des recommandations issues des audits. Il sert ainsi de repère aux acteurs du système sanitaire afin d'améliorer la qualité des soins offerts à la mère et au nouveau-né. | Entretien CEHRRUD, Mai 2021, Benin |
| <ul style="list-style-type: none"> FNUAP : clé dans le comité national et réflexion sur le repositionnement de la MDSR en analysant les facteurs favorisant et les défis, avec ANSS (créé en 2017) <p>Autres PTF impliqués :</p> <ul style="list-style-type: none"> USAID - Integrated Health Services Project Activities Enabel – 4 départements supplémentaires (formation) dans le cadre du programme P@SRIS | Entretien, ONG national, Mai 2021, Benin |
| <ul style="list-style-type: none"> On doit reconnaître que UNFPA a joué un rôle capital dans l'introduction et la mise à échelle de SDMR au Bénin. C'est à travers leur programme avec CERRHUD qu'ils ont pu démontrer le bien-fondé de l'approche et contribué à son adoption. La préparation du guide national, le suivi et les rapports annuels continuent d'être une activité de soutien importantes pour UNFPA et le ministère. | Entretien l'OMS, Benin, Mai 2021 |

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| <p>Perceptions</p> <ul style="list-style-type: none"> ● Les activités MDSR apportent beaucoup mais le « R » [riposte] est minuscule, or, c'est le R qui règle le problème. Donc d'autres partenaires devraient aider pour la riposte, mais ce n'est pour l'instant pas satisfaisant : Exemple : Qualité de référence fait que ça ne marche pas (avoir ambulance prend 18 mois et celui qui la demande a été affecté quand l'ambulance arrive) ; il y a un problème avec l'appropriation des recommandations issues des revues et la Direction du Ministère devrait être systématiquement représentée, pour prendre les mesures nécessaires. Cependant nous pouvons prendre des mesures internes mais nous n'avons pas d'influence sur les facteurs externes à l'hôpital. | <p>Entretien, Ministère de la Santé, Management, Cotonou, Mai 2021, Bénin</p> |
| Sudan | |
| <p>Implementation of MDSR in Sudan</p> <ul style="list-style-type: none"> ● In Sudan, MDR started since 2009, where clinical causes of MD were identified: haemorrhage, hypertensive disorders or its complications and sepsis. Areas of delays were determined after regular reporting of maternal death through focal person networks and discussion of MD at states maternal death review committees (SMDRCs) and NMDRC. In 2014, MDSR was introduced in Sudan using WHO guidance, hoping that with regular review of MD and analysis of causes of death; Recommendations could be made and implemented to reduce maternal mortality at states and country level through access to quality maternity care. | <p>UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018</p> |
| <p>Progress in 2018</p> <ul style="list-style-type: none"> ● Knowing the number of maternal deaths alone is not enough to reach the SDGs, but it is important to identify causes and implement intervention to prevent further maternal death ● In Sudan; maternal death review (MDR) has been the standard method for determining maternal mortality, establishing the clinical causes of maternal death, and identifying areas of delay since 2009. ● Although this maternal mortality ratio (114 maternal deaths per 100,000 live births) is still high, with discrepancies between states, it is the least to be reported over the last nine years since establishing of MDR system. | <p>UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018</p> |
| <p>Where and how to strengthen MPDSR</p> <ul style="list-style-type: none"> ● About two-thirds of the deaths (66.4 per cent) occur within the first 24 hours of their arrival at the hospital. ● Some stakeholders interviewed advocate for the monitoring system to integrate the socio-economic determinants of maternal mortality, to involve private sector data and the study of near miss maternal morbidity. It is clear that in most cases, despite political declarations and integration into action plans, the MDSR is still considered a pilot project and suffers from its institutionalization in maternal health programmes and in information and epidemiological surveillance. There is now a need to institutionalize this intervention at central and regional level by integrating the different partners and adapting a new legislative framework. | <p>Université Mohammed VI des Sciences de la Santé and UNFPA Arab States Regional Office, Regional MDSR Workshop, Casablanca, 22-23 July 2019. p.69</p> |
| <p>Mixed quality and variable results</p> <ul style="list-style-type: none"> ● Each year there was a national MDSR report containing evidence-based recommendations, addressing policy makers, managers, care providers involved in women health at hospitals and community. ● However, the reports and evaluation during the last five years showed that MDSR is still suboptimal in many states, despite the investments and efforts of FMoH and the supporting partners; particularly UNFPA, UNICEF, WHO and national agencies. | <p>UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018, UNFPA Khartoum</p> |

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| <ul style="list-style-type: none"> The reports also showed that there is relatively low information obtained about community related factors affecting maternal mortality, under reporting of early pregnancy related maternal death, and health determinants affecting maternal health. | |
| <p>Supportive supervision for MDSR is important particularly in the initiation stage.</p> <ul style="list-style-type: none"> In Sudan at national level, it is almost regular, covering all states, at least once a year for each state. However, at states level, it is infrequent, largely dependent on donor funding, reflecting the weak health system at states, which is consistent with that found in many African countries. During these supervision tours, many gaps between national recommendations of the NMDRC and implementation at state levels were reported in most of the states. During the last five years, management protocols for emergency obstetric problems (haemorrhage, hypertensive disorders and its complications and sepsis), have been designed and endorsed, however implementation and adherence to is so deficient in almost all health facilities. Poor live birth registration in health facilities and home deliveries have been reported, most of the statistical records are incomplete or not available. The SMDRCs do not regularly meet to discuss their maternal deaths to timely generate recommendations and implement interventions for reducing maternal deaths. | <p>UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018, UNFPA Khartoum</p> |
| <p>Integration of perinatal deaths</p> <ul style="list-style-type: none"> “Looking at UHC as a proxy for universal SRH coverage, UNFPA’s Arab States Regional Office in partnership with University of Mohamed VI for Health Sciences launched an in-depth multi-country MDSR assessment in 2017 that covered ... Sudan...UNFPA supported a regional experts’ group meeting to discuss the findings of the assessment that came up with a way forward that included provision of support to add perinatal deaths surveillance to MDSR, considering the integration of “near-miss” cases and the specificities of humanitarian settings.” | <p>Université Mohammed VI des Sciences de la Santé and UNFPA Arab States Regional Office, Saving Mothers' Lives Casablanca, 22-23 July 2019, p.2</p> |
| <p>Achievements:</p> <ul style="list-style-type: none"> MDSR is accepted and ongoing at national and states level, with regular notification, review, and regular national report with many interventions being recommended and implemented. Good investment, particularly from relevant donors on midwifery training and FMOH and SMOH in recruiting midwives in the health system to improve women’s health. However in-service training is poor. Management protocols for emergency obstetrics have been implemented but are poorly adhered to. | <p>UNFPA, Maternal Death Surveillance and Response Report, Sudan, 2019</p> |
| <p>Conditions for success: Leadership</p> <ul style="list-style-type: none"> Functioning MDSR requires teamwork and commitment from all partners. Frequent turnover of team dependent persons (RH focal persons and registrars at states level) can negatively affect the process. MDR meetings should not depend solely on focal persons and should continue even in their absence. Providing incentives such as sponsoring the meetings may motivate participants. Usually review teams need technical and moral support as well as building their technical analytical skill. They need to be guided by a senior particularly expert doctor or a consultant obstetrician. It needs guidance, coordination, and support from FMOH and SMOH by allocation of resources in each annual health budget. | <p>UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018</p> |

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| <ul style="list-style-type: none"> ● FMoH is taking a leadership role in supervision, training and availing of requirements, however other partners (UNFPA, UNICEF and WHO) play a vital role in sponsoring national and states meeting and the supportive supervision tours. More intensive advocacy is needed to institutionalize MDSR at HMIS. | |
| <p>MPDSR reforms to strengthen systems</p> <ul style="list-style-type: none"> ● Survey data were vertical but a review “is underway now to identify options and opportunities for integration of MPDSR into the national health information system”. ● Technical Working Group members and the group itself draws on support from MHTF for meetings. Currently, WHO and UNFICEF participate on a technical level only. The FMoH funds about 20 per cent of needs and MHTF funds the other 80 per cent. ● However, in addition, the FMoH aims to integrate the MPDSR into the national and state health system such that it will become part of the routine health services management approach. Previously it had been set up as a parallel and external system affiliated to the Sudan Medical Board. ● The current reform process underway is aimed at trying to integrate the system into the national health system more operationally so linking it to the levels of care (primary, secondary, and tertiary etc.) and to the DHIS. This is a slow process, and the working group will review progress later in 2021 to decide whether and how to make adjustments. | <p>Interview, RH Team, UNFPA CO Khartoum, 17 June 2021</p> |
| <p>UNFPA Support</p> <ul style="list-style-type: none"> ● UNFPA works on MPDSR in an active and highly engaged way. There have been challenges documenting the programme, however. ● UNFPA supports the MPDSR through supporting the development of policy and support the regular meetings at federal and states levels and capacity building programmes. ● In 2020, the FMoH started a process of updating the MPDSR system and planning a new approach. | <p>Interview, RH Team, UNFPA CO Khartoum, 17 June 2021</p> |
| <p>Reporting activities 2020</p> <ul style="list-style-type: none"> ● This activity includes notification, investigation, committee’s meetings, supervision, production of MDSR annual report and Operational support to MDSR national registry office. | <p>Review of programme activities, UNFPA CO, Sudan, 22 June 2021</p> |
| <p>Partnerships</p> <ul style="list-style-type: none"> ● WHO and UNICEF have become more engaged and have supported the integration of the perinatal/newborn death audit processes with the maternal death audits that had been underway for some years. | <p>Interview, RH Team, UNFPA CO Khartoum, 17 June 2021</p> |
| Togo | |
| <ul style="list-style-type: none"> ● Entre 2014 et 2019, il y a eu une cascade de formation des prestataires pour pouvoir faire la surveillance des décès maternels, c’est à dire lorsqu’il y a un décès, pouvoir le notifier, reconnaître que c’est un décès maternel. Au sein de chaque structure, il y a eu une équipe formée qui se réunit pour passer en revue toutes les étapes de la prise en charge de la femme décédée afin d’identifier après, les facteurs ayant contribué à ce décès et les stratégies de mitigation de ces facteurs. Le constat est que les décès maternels ne sont pas systématiquement notifiés au niveau supérieur. ● Lorsqu’on prend le volet audit, c’est dire réunion des audits pour pouvoir passer en revue les décès, les audits ne se réalisent pratiquement pas. Entre 2017 ou 2018, l’UNFPA a appuyé la DSMI pour faire un état des lieux sur les équipes qui sont toujours fonctionnelles après les formations de 2014 et 2015 et identifier les besoins de renforcements des équipes. | <p>MoH staff, June 2021, Togo</p> |

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| <p>Après ce suivi, les sites où on s'est rendu compte qu'il manque de personnels ayant les compétences pour conduire ces audits ont été accompagnés. L'année qui a suivi a consisté à mettre en place un mécanisme de suivi et d'accompagnement de ces structures.</p> <ul style="list-style-type: none"> • Au cours des suivis, la stratégie consiste à faire une formation sur site pour présenter toutes les étapes de la surveillance des décès maternels, comment réaliser les audits avec des cas pratiques. Les suivis se font sous forme de transfert de compétences, ce qui permet aux structures de réduire le nombre de décès non notifiés. En 2020, les suivis n'ont pas été étendus à toutes les régions. Une partie de la région des savanes en a bénéficié. L'OMS a aussi contribué à soutenir une partie de la région. | |
| <p>Suivi et accompagnement des équipes formés à la surveillance des décès maternels</p> <ul style="list-style-type: none"> • Formation des prestataires pour pouvoir faire la surveillance des décès maternels, • Plaidoyer pour la mise à disposition d'une équipe formée au sein de chaque structure constats: décès maternels non systématiquement notifiés au niveau supérieur; • Réalisations non systématiques des audits état des lieux sur les équipes fonctionnelles Identification des besoins de renforcements de capacités. • Accompagnement des sites manquant de personnel qualifié • Mise en place d'un mécanisme de suivi et d'accompagnement des structures manquant de personnel qualifié sous forme de transfert de compétences, • Suivis non étendus à toutes les régions en 2020 (une partie de la région des savanes en a bénéficié) • L'OMS a aussi contribué à soutenir une partie de la région. | MoH staff, June 2021, Togo |
| <p>Autres partenaires engagés dans SDMR ?</p> <ul style="list-style-type: none"> • OMS: L'implémentation de la Surveillance des décès maternelle était à l'initiative de l'OMS; actualisation des supports en 2020, actualisation des supports et outils de gestion de la surveillance des décès maternels. Fiches de notification des décès maternels rédigés, financement des équipes de suivi. Elaboration des directives opérationnelles pour la surveillance des décès maternels et péri-natals avec l'appui technique et financier de l'OMS; supervision des SONU dans certaines régions, intervient dans la qualité des soins. | MoH staff, June 2021, Togo |
| <p>Phase 2 (21-23 November):</p> <ul style="list-style-type: none"> • MPDSR Knowledge sharing and capacity building workshop. The following criteria will be used to select countries for this phase of the workshop: 1. Countries that started implementing perinatal death notification. 2. Countries that can show examples of good quality MPDSR processes as per the set standard (it could be at health facility or sub-national or national level). 3. Countries that are under the quality improvement network (five countries). 4. Small countries currently not covered under the quality improvement network. 5. Due attention will be paid to ensure representation from the Southern Region, Eastern Region and Indian Ocean Islands. • A total of 152 participants from 32 countries (Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroun, Chad, Congo Brazzaville, Cote D'Ivoire, DRC, Eswatini, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Tanzania, Togo, Uganda, Zambia, Zimbabwe) will be invited for the 2nd phase of the workshop. | UNICEF, WHO, UNFPA, Maternal Perinatal Death Surveillance and Response Capacity Building: Joint WHO/UNFPA/UNICEF Workshop - Concept Note, 2018 |

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| Uganda | |
| <p>Implementation of MPDSR in Uganda</p> <ul style="list-style-type: none"> ● In 2017, the MoH adopted the WHO MPDSR guidelines and rolled them to all the districts as a key tool for quality improvement and accountability in MNH. | <p>MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response Report 2017/18, 2019</p> |
| <ul style="list-style-type: none"> ● The MoH introduced a safe motherhood campaign in 2002, which led to adaptation of the World Health Organization (WHO) guidelines on MDR in 2004. However, due to continuing high MMR, maternal deaths were declared a national emergency by the President in 2008 and all hospitals were required to routinely report and review all maternal and perinatal deaths that occur at their facilities to the national level. MPDR committees were established at both national and regional referral hospitals and were later cascaded to the General hospitals and Health Centre IVs. Standard reporting tools were developed and health workers in some districts and facilities were trained to conduct MPDR. The MoH and its partners supported confidential enquiry into maternal death. ● In 2013, WHO provided guidance on Maternal Death Surveillance and Response (MDSR) to guide countries in their MPDSR processes. ● The guidelines o 2017 are an adaptation of the WHO MPDSR guidelines. They are also based on lessons learnt over years as part of the Quality improvement processes for MNH. ● Several partners namely: UNFPA, WHO, UNICEF, USAID, URC-ASSIST, CDC World Bank, Save the Children in Uganda and, UNHCO have supported the MoH in implementing the MPDR process. | <p>MoH Uganda, Maternal and Perinatal Death Surveillance and Response Guidelines, 2017</p> |
| <ul style="list-style-type: none"> ● MPDSR is a quality improvement process. There is a need to work towards completing the whole cycle: the first big struggle is to have the appropriate tools in place. There are very good strategies and guidelines – and lots of discussion on how to train MPDSR to manage – but how do we ensure the right forms? ● MPDSR is at the facility level still – the community level is not yet involved. There is a need to look at how to look at maternal deaths in the community and add that piece as well. Also, the response part, that is where the discussion happens, for example with the PPH framework and the revision of guidelines. There is currently a very big push towards reducing deaths due to PPH – but that is just one piece of the puzzle. The main question is how to make it happen – to improve the quality of maternal health services – the referrals from community to HCIII, and from HCIII to HCVI – how can we connect all these pieces together? There needs to be a systems approach – you need to increase the number of midwives, but if you do not have gloves, you might know how to use magnesium sulphate, but the drug is not available. The holistic approach for quality of care in MPDSR – that has to be emphasized. The blaming of the health worker is long gone – not so much an issue anymore – but now more looking at how to improve the system around it. | <p>Interview, Development partner, Kampala, May 2021</p> |
| <p>UNFPA support for MPDSR</p> <ul style="list-style-type: none"> ● National MPDSR committee meetings were revitalized through the conduct of quarterly meetings and regional confidential inquiries. At district and facility levels, UNFPA supported the MoH to conduct facility-based mentorships to build capacity of health workers and facilities committees to conduct MPDSR, including the review of deaths and reporting into the HMIS. Maternal death notification increased from 59 to 76 per cent, and reviews increased from 51 to 66 per cent between 2019 and 2020, respectively. MHTF support to the MoH for these activities was complemented with funding from Sida, USAID and CHAI. | <p>UNFPA Uganda, Final Annual Report for MHTF, 2020</p> |

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- **UNFPA participated in joint weekly meetings with the MoH National MPDSR committee**, which focused on MPDSR at National Hospitals (Kawempe and Mulago Women’s and Neonatal Specialized Hospitals). These meetings have served to **spur action and strengthen response to maternal and perinatal deaths through confidential inquiries**. In addition, in response to observed gaps, UNFPA mobilized funding from MTN-Uganda to support renovation and equipment for the Neonatal unit at Kawempe National Referral Hospital and a consultant Neonatologist to support its establishment and functionality. Between October and November 2020, the number of neonatal deaths declined from 111 to 67 deaths at the hospital.
- **“With the MTHF catalytic funds, UNFPA supported the MoH** to strengthen the response aspects of the MPDSR in the following ways; (1) conduct **weekly high level multi sectoral review meetings** at the Kawempe National Referral Hospital (Referral hospital for Maternal Health), (2) support **regular confidential inquiries** in select regional Referral Hospitals which reported high referral rates and maternal deaths, (3) supported **Kawempe National Referral Hospital (NRH) to support high volume lower lever facilities** in the Kampala Metropolitan area, and (4) supported the **functionalization of the Neonatal Intensive Care Unit (NICU)** in Kawempe NRH through the hiring of a neonatologist, who built the capacity of the care teams. During this period there has been an observation of reduction of neonatal deaths at the facility.” (p.3)
- **“The National MPDSR report for FY2019/20 was Compiled and Validated by a team of national stakeholders in the National MPDSR committee and was also presented to the MCH cluster which forwarded it to the MoH Senior Management for Adoption and Final endorsement by the Director General of health services.” (p.4)**

- UNFPA supported MoH in the implementation of MPDSR cycle at national and sub-national levels **with emphasis of strengthening maternal death notification, quality reviews and responsiveness to recommendations** as part of the key indicators for improving service delivery in health facilities.
- UNFPA supported **the compilation and dissemination of the Annual MPDSR Report** (September 2019) to ensure continued quality improvement. There was increased awareness among stakeholders on the use of MPDSR as a quality improvement tool for mitigating occurrence of maternal deaths. However, the **functionality of MPDSR Committees at district and health facility level remained a key challenge and the main weaknesses were** as follows:
 - Majority of facility MPDSR committees were not fully constituted and non-functional.
 - The MDPSR committees at both district and facility levels were not well oriented on the process of MPDSR, the formulation of the MPDSR committee, the roles of the members and the reporting mechanism to MoH.
 - The revised tools were not available at both district and facility levels.
 - Inadequate technical support supervision provided by some district MPDSR committees to health facilities; and this was because the district MPDSR committees were not functioning.
- To improve the MPDSR system further, **the following aspects need to be advocated by UNFPA** in liaison with MoH:
 - Strengthen the MPDSR committees at district and facility level through orientation of the members about their roles and responsibilities on the committees
 - Strengthen the community level intelligence/surveillance for maternal deaths
 - Encourage and monitor pregnancy mapping and tracking by VHTs and
 - Orient political/technical leaders on the importance of MPDSR and safe motherhood” (pp. 34-35)

GoU and UNFPA, UNFPA 8th Country Programme, 2016-2020 Evaluation Report, 2020

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| <ul style="list-style-type: none"> ● UNFPA supported the MPDSR process by funding specialist team visits to lower-level facilities to understand the root causes of the high number of referrals and increase in maternal and perinatal deaths at Kawempe. UNFPA also supported the MoH in the implementation and follow-up on recommendations and action points. In 2020, the MoH senior management (including permanent secretary and directors of department) visited Kawempe to understand the drastic increase in maternal and perinatal deaths. ● As a result, the PS recommended to send technical teams to visit the referring facilities, help address the gaps and causes at this level, reduce the referrals, and therefore decongest Kawempe. UNFPA funded those team to visit the lower-level facilities in November and December 2020 and will soon fund follow-up visits through the MoH. As a result, there has been a 45 per cent reduction in the number of referrals coming to Kawempe from these health facilities. | <p>Interview, MoH service provider, Kampala, May 2021</p> |
| <p>Government commitment for MPDSR</p> <ul style="list-style-type: none"> ● The MoH places a top level of priority on MPDSR, supported by the World Bank Uganda Reproductive, MCH Services Improvement Project (URMCHIP), UNFPA, USAID, WHO, UNICEF and CHAI among others. In 2020, with maternal deaths spiking, it renewed efforts to implement MPDSR as an important continuous quality improvement (CQI) tool in the provision of MNH services. “Using the revised National MPDSR guidelines, the focus for 2020 has been on increasing mandatory notification and reporting for all maternal and perinatal deaths, functioning of facility, district and national MPDSR committees, review of all deaths and response by implementing recommendations at the different levels.” (p.7) ● “Leadership on MPDSR has turned the tide on quality of care for Maternal health starting with National and Regional Referral Hospitals plus Urban Authorities. The leadership of the MoH top leadership and involvement of critical stakeholders for commodity supply, urban authorities, referral hospitals and donors; has greatly reduced unnecessary referrals along the referral pathway for maternal health. These regular (weekly) interactive meetings have also been platforms for resource mobilization, and efficient allocation. They have also been an accountability platform for resources allocated as well as collective problem solving.” (p.19) | <p>UNFPA Uganda, Final Annual Report for MHTF, 2020</p> |
| <p>UNFPA support to for follow-up of MPDSR action points/recommendations</p> <ul style="list-style-type: none"> ● UNFPA supported root cause identification at regional referral hospitals (RRH): UNFPA <u>Sida</u> funds the specialist teams to visit lower level referring hospitals to discuss and identify the root causes (i.e. those facilities referring to Kawempe and Mulago). ● Support for a new neonatal unit at Kawempe: UNFPA provided equipment and materials for the new neonatal unit at Kawempe funded a neonatologist to come up with protocols of care, train and mentor the teams through the diff drills of care for emergency conditions for the neonates, how to use the new equipment in the neonate intensive care unit etc. <p>Results:</p> <ul style="list-style-type: none"> ● “Unnecessary” referrals to Kawempe almost dropped to zero – e.g. the blood supply to the regional referral hospitals (RRH) improved (through strengthened blood supply chain) and blood transfusions are now handled at that level, and no longer referred to Kawempe. ● Kawempe has been decongested through reduction of referrals, but also by referring women who need C-section from Kawempe to other hospitals, if the theatre at Kawempe is full (i.e. strengthened referral system between National Referral Hospital and Regional Referral Hospitals) | <p>Interview, UNFPA Uganda national staff, May 2021</p> |

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- **“With the MTHF catalytic funds, UNFPA supported the MoH to strengthen the response aspects of the MPDSR in the following ways; (1) conduct weekly high level multi sectoral review meetings at the Kawempe National Referral Hospital (Referral hospital for Maternal Health), (2) support regular confidential inquiries in select regional Referral Hospitals which reported high referral rates and maternal deaths, (3) supported Kawempe National Referral Hospital (NRH) to support high volume lower lever facilities in the Kampala Metropolitan area, and (4) supported the functionalization of the Neonatal Intensive Care Unit (NICU) in Kawempe NRH through the hiring of a neonatologist, who built the capacity of the care teams. During this period there has been an observation of reduction of neonatal deaths at the facility.” (p.3)**
- **“The National MPDSR report for FY2019/20 was compiled and validated by a team of national stakeholders in the National MPDSR committee and was also presented to the MCH Cluster which forwarded it to the MoH Senior Management for Adoption and Final endorsement by the Director General of health services.” (p.4)**

UNFPA Uganda, Final Annual Report for MHTF, 2020

- MHTF funds and advocacy for the compilation of the annual MPDSR report has been catalytic since it gained the interest and support of the MoH, attracted other donors/partners, and Sida-funded UNFPA to operationalise MPDSR at the district level. UNFPA has played an instrumental role, alongside WHO, in advocating for the MPDSR process and making the evidence about the root causes of maternal and neonatal deaths available. MoH gained interest and picked it up, and the MPDSR is now spearheaded by the senior management of the MoH. UNICEF and USAID came on board with technical and financial support later on (although it is not clear exactly what year). Moreover, Sida has come on board and started funding UNFPA to strengthen district MPDSR committees.
- As a result of the weekly MPDSR meetings (supported by UNFPA and other donors), **a national Postpartum Haemorrhage (PPH) Action Framework was developed to address the weak blood supply chain system**, causing women to die from PPH. As part of this, UNFPA supports research and revision of the list of live-saving drugs, i.e. shifting from oxytocin (which requires a cold chain) as first line drug to other heat stable drugs.
- **“We started developing national MPDSR reports in 2015; the first was published around 2016. Since then, we have seen that PPH is the major cause – it is globally like that – but for us it is consistently high. The MPDRST reviews are only about 66 per cent (2020) – so only 66 per cent of reported death (not notified) were reviewed.”**
- UNFPA/MHTF has contributed the MPDSR alongside WHO. At recent time, MHTF has supported that MPDSR reports come out on a regular annual basis – what the main issues are – tasking the MoH to commit, to support some of these areas that have been identified as weak – **the MPDSR annual report is bringing out some of those gaps.** **“This year, we need to have a deliberate PPH framework – to address the PPH root causes – The reports were demonstrating that this was the key issue – and it informed the decision to develop a PPH framework.”**
- Regularly, **every year, MHTF has funded the compilation of data, analysis etc. of the annual report.** UNFPA also funds the districts to conduct regular MPDSR at the district and facility level, so that has improved the functionality of these committees.
- For the first report, **WHO and UNFPA both provided funding to compile data from the last 3 years.** UNFPA funded the dissemination of the report, including at district level. It is now a country-led process to establish the MPDSR report. Last year, **MHTF funded the MPDSR annual report – USAID funded further dissemination of results** – so lower level RHH and HC III ad VI can take action, develop action plans. WHO has also added resources. UNFPA has contributed to the compilation of

Interview, UNFPA Uganda staff, Kampala, May 2021

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| <p>the report. In 2018, it was only UNFPA who supported a very comprehensive compilation and analysis. The others provided technical input, but not funding. In 2019, we picked interest from other partners who supported, they got interested, and the dissemination was expanded. UNICEF, they also contribute, especially the perinatal aspect.</p> <ul style="list-style-type: none"> • “After the very first report 2016, there was “laxity” – not very much interest for this report. MHTF then started supported the annual reports – every year very consistently. UNFPA and WHO advocated very strongly for the MPDSR report in the beginning, other donors did not see the importance, even the MoH was not that much interested. It was pushed by UNFPA and WHO.” • UNFPA mainly supports the compilation, not the dissemination. • “When the first reports came out, MoH realised what the gaps where, and there was a need to take action. Also, with the deaths happening, we started improving surveillance – how many deaths have happened where. So, they started picking interest. Also, the president of the country is supporting MPDRAT, he instructed the MoH to investigate and document every maternal death. He usually asks what the responsibility is for those mothers who died. That political will and support increased the interest and demand for the MPDSR report.” • Previously, the analysis happened ad hoc – parliament asked to investigate a case of maternal deaths. But now it is a structured process. | |
| <p>MoH perspectives on UNFPA support</p> <ul style="list-style-type: none"> • MPDSR is a quality improvement approach and meant to work as an entry point to identify the critical gaps and issues that lead to maternal deaths. “With UNFPA support we are able to analyse the data every week, take action every week, and follow-up on the actions. Initially, we were at a quarterly level for MPDSR meetings, but now they are weekly.” • It would be helpful to support districts with data or IT equipment, so that the DHOs can participate in those meetings (ADHO) via Zoom – they need data etc. “We are trying to use technology to ensure that there is a close exchange of ideas, also for the good practices. Even DHO peer learning and peer support can help – and that is where we need UNFPA and others support.” | <p>Interview, MoH official, Kampala, May 2021</p> |
| <ul style="list-style-type: none"> • UNFPA does not have resources to support MPDSR in a country of 130-140 districts. MHTF only supports the compilation of the national report last year, but UNFPA had Sida funds to support MPDSR district capacity building in 14 districts. Sida also funded Kawempe and Mulago MPDSR. • “UNICEF also can fund MPDSR in other districts. In regions where we “converge”, i.e. UNICEF and UNFPA in West Nile – we have created quarterly coordination meetings WHO-UNICEF-UNFPA – specifically for West Nile and Acholi region. They are both there, but they are doing <i>similar</i> things – not the same. The coordination meeting is to ensure that there is no duplication or overlap – but expansion of coverage - ensuring maximum coverage. Both UNICEF ad UNFPA have IPs there, and we meet to make sure that their support is well coordinated. I have asked UNFPA and UNICEF to ensure that their regional offices also make similar coordination meetings. It was one of UNFPA conclusions of last year – that we needed to have those regional strong platforms UNICEF-UNFPA-WHO. Not sure if it has yet been operationalised.” | <p>Interview, UNFPA Uganda national staff, Kampala, May 2021</p> |
| Zambia | |
| <p>Development of MPDSR Plan, Strategy and Guidelines</p> | <p>UNFPA, Zambia. 2019 Annual Report – Zambia. 2020.</p> |

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| <ul style="list-style-type: none"> ● UNFPA Zambia supported the MoH to develop an MPDSR plan aligned to international standards. The plan includes targeted interventions aimed at addressing critical gaps that cause or contribute to preventable maternal deaths. ● UNFPA provided support to strengthen capacity of a team of 30 technical staff from all provinces with representatives from the MoH and development partners, including the national MPDSR Committee appointed by the Minister of Health, to provide oversight to the MPDSR system through the following processes: <ul style="list-style-type: none"> ○ Review of maternal deaths ○ Identification of factors contributing to the death ○ Develop of response plans to prevent recurrence ● UNFPA also supported the ZAGO to draft a position paper of strategic interventions to implement to address maternal mortality. | |
| <ul style="list-style-type: none"> ● “In an effort to strengthen the national Maternal Perinatal Death Surveillance and Response (MPDSR) system and end preventable maternal deaths, the CO supported the MoH at national level to review the MDSR guidelines and tools and incorporate the perinatal component as well as align the document to international standards. | UNFPA, Zambia. MHTF Annual Report, 2020. Undated. |
| <ul style="list-style-type: none"> ● UNFPA has strengthened capacity in MPDSR. Last year, the CO supported the review of national guidelines in collaboration with a consortium of UN agencies helping with the process, i.e., WHO, UNICEF and World Bank. Earlier this year, the draft was validated, and it is awaiting the printing, dissemination and roll-out. There is a plan with the MoH on how to implement the rollout. Representatives are selected from the 10 provinces to do their own dissemination, e.g., PHOs will disseminate to districts and then down to health facilities. When there are windows of opportunity, the MHTF will co-fund and support the provinces to roll-out. | Interview, UNFPA Zambia staff. August 2021. |
| <p>Capacity-building in MPDSR processes</p> <ul style="list-style-type: none"> ● In addition to this, the CO built capacity of a team of 35 technical staff from MoH and development partners, including members of the national MPDSR committee appointed by the Minister of Health, in the conduct of quality MPDSR processes and providing oversight to the national MPDSR system. ● The CO supported the conduct of MPDSR processes in all supported provincial to review maternal deaths, identify factors contributing to the death and development response plans to prevent recurrence. Some UNFPA supported districts have made gains in reducing maternal deaths through initiatives of early identification of at-Risk pregnancies, follow up and accommodating the pregnant women at facilities to facilitate timely interventions.” (pp. 1-2) | UNFPA, Zambia. MHTF 2019 End-of-year Report. Undated. |
| <ul style="list-style-type: none"> ● The CO supported MPDSR processes in all supported provinces that resulted in reviews of maternal deaths, identification of factors contributing to the deaths and development of response plans to prevent recurrence. As a result of the response plans some of the supported districts have made gains by implementing initiatives such as early identification of at-risk pregnancies, follow up and accommodation of pregnant women at health facilities, to facilitate timely management of labour and its complications. ● The CO continued to support the implementation of the MPDSR Plan developed in 2019 to ensure that maternal and perinatal deaths are part of the multi-sectoral approach to addressing preventable maternal and perinatal Deaths. The plan outlines targeted interventions aimed at addressing critical gaps that cause or contribute to preventable maternal deaths. The plan also augments the national response to the declaration made by the President in May 2019 on maternal and | UNFPA, Zambia. MHTF Annual Report, 2020. Undated. p.4 |

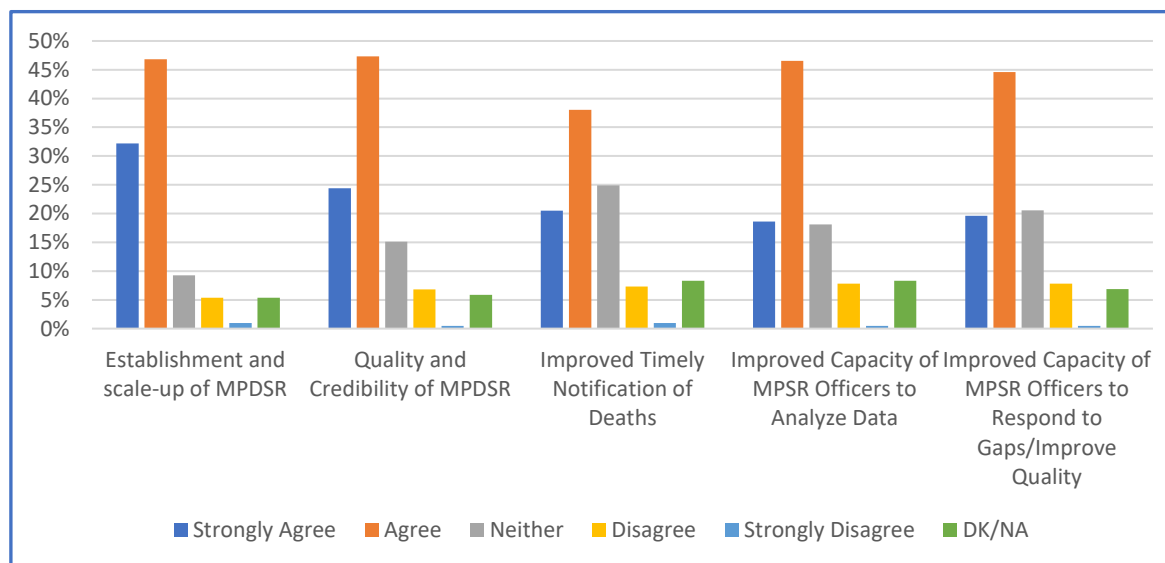
| Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive | |
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| <p>perinatal deaths as a public health emergency. This has resulted in strengthening the National MPDSR committee appointed by the Minister of Health, to conduct quality MPDSR processes and provide oversight to the national MPDSR system.”</p> | |
| <ul style="list-style-type: none"> ● MHTF supported MPDSR, a central piece of programme management at provincial level. UNFPA also provides support at national level to clean up data and inform planning. “The beauty of the way MPDSR is structured, we support the national level as well as the Provincial level in the three provinces.” Basically, a national level committee that has been appointed to review maternal deaths. At MoH level they do this on a weekly level. Former President made maternal mortality a national priority. For every death that occurs, the facilities are supposed to immediately report. Facility notifies DHO, notifies PHO then PH Director at MoH. Then the countdown begins for receipt of a detailed report. Committees are instituted at all levels to look at preventable causes are addressed. The institutionalization of MPDSR is at different levels; staff turnover affect this. “We have noticed some gaps and are trying to work on that: at facility level, whenever a death is being reviewed there is fear. Do not get the depth and detail.” Confidential inquiries into maternal deaths; anonymous teams. The Zambia CO recently reached out to the EASRO since they have been doing them for a long time – want TA to train MoH and ZAGO to probably help with running these confidential. | <p>Interview, UNFPA Zambia national staff. August 2021</p> |
| <ul style="list-style-type: none"> ● “We’ve seen a lot of improvement in what the MPDSR should be. The gaps I see – we need to keep pushing people. Whenever there is a mortality, people in that facility should be interested in reviewing the death – they should be able to sit and say how this happened, how to prevent. As a MoH, we have taken certain steps that we should not leave to facilities to review alone. They should share with the rest of country in an organized way. As we move forward, we look at outcomes of new-borns and learn more about general management of mother.” ● Mortality reviews have been conducted for over a year now. Since we have started, the number of deaths/week have decreased. “We had more than 20 mortalities each week, but for quite some months, we have not had a figure above 20. Some have recorded below 10. Though even from the management, when we discuss with provinces, there has been a certain level of change.” | <p>Interview, MoH Zambia national staff. August 2021.</p> |
| <ul style="list-style-type: none"> ● UNFPA has assisted in strengthening the review of maternal and prenatal deaths. “Behind every maternal or prenatal death, there is a lesson to learn in terms of what we could have done better so that we do not lose another life in a similar manner.” UNFPA has sponsored quarterly maternal and prenatal death reviews. Staff sit to review every maternal and prenatal death. The review is done immediately and as a province, reviews are conducted to discuss those maternal and prenatal deaths. ● As a result, the situation in the province has improved. “At one time in 2019, we had 69 deaths and last year, we recorded 44 maternal deaths and currently, this year in August, we have recorded 24 deaths. If we continue to improve, we can see maternal deaths continue to reduce. We may record 40 or 39 by the end of this year.” | <p>Interview, MoH staff, Western Province. August 2021.</p> |
| <p>Areas to strengthen</p> <ul style="list-style-type: none"> ● Progress has been made in establishing national guidelines and a system for conducting weekly reporting. One missing area is to strengthen the area of confidential inquiries around maternal deaths and to produce regular reports. In the region there are a couple of countries where there are annual reports to review and analyse deaths over past three years. “These reports attract discussion about changes. Something we need to do in Zambia.” | <p>Interview, UNFPA Zambia national staff. August 2021</p> |

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive

- The work on MPDSR has been evolving over time – started off with a lot of advocacy and sensitization. In many countries, once you report a maternal death that occurred within a health facility, who is responsible, blame. Inquiries to improve the quality of care – but it has not fully developed until now. Now there are district reviews that take place, there are updated guidelines that now include the perinatal component. “This year, the MoH has requested TA from UNFPA to strengthening the area of confidential inquiries which should help move towards the biannual reports. **At national level, would be important to have a committee, quasi-independent with researchers, academics, ministry, to put together the report.”**

Online survey

Question 8: UNFPA Support to MPDSR



Online survey conducted between May and July 2021

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| Establishment and scale-up of MPDSR | 32.20% | 46.83% | 9.27% | 5.37% | 0.98% | 5.37% |
| Quality and Credibility of MPDSR | 24.39% | 47.32% | 15.12% | 6.83% | 0.49% | 5.85% |
| Improved Timely Notification of Deaths | 20.49% | 38.05% | 24.88% | 7.32% | 0.98% | 8.29% |
| Improved Capacity of MPSR Officers to Analyse Data | 18.63% | 46.57% | 18.14% | 7.84% | 0.49% | 8.33% |
| Improved Capacity of MPSR Officers to Respond to Gaps/Improve Quality | 19.61% | 44.61% | 20.59% | 7.84% | 0.49% | 6.86% |

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| Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal, and neonatal deaths in national and sub-national systems and increased implementation of responses | |
| Indicators: | |
| <ul style="list-style-type: none"> • Quantifiable increase in the notification of deaths to health facilities, districts, and other authorities • In target areas, increasing or continuing number and frequency of MPDSR events and hearings with multi-stakeholder participation • Examples of policies and processes to support improved quality and comprehensiveness of death audits at national and at sub-national levels • Examples of UNFPA efforts to strengthen QI processes, tools and data collection at national and sub-national level linked to MPDSR • National and sub-national health and district supervisory officers in areas supported by UNFPA implement MPDSR monitoring on a regular basis and utilize findings to support improvements in services • Views of health officials, including facility managers, providers, and community members regarding credibility of MPDSR processes. | |
| Observations | Sources of evidence |
| Global | |
| <ul style="list-style-type: none"> • MPDSR is a critical area for advancing maternal health but is not included often in meetings in the global sphere. It is a very focused topic and not many H6 efforts are focused on this. In the end we have managed to do quite a lot with a small number of resources. We put a lot of effort into supporting annual MPDSR reports and trying to institutionalise notification and review. Notifications are going up which is a good point. | <p>Interview, UNFPA HQ Staff, February 2021</p> |
| Regional | |
| <ul style="list-style-type: none"> • Although MPDSR has been prioritized in the ESA countries, the focus has been on facility based maternal deaths and the community identification of maternal death has been neglected. It is critical to strengthen this component of MPDSR to progress towards zero preventable maternal death. • The case study found none of the countries have used their community death notification data for preparing an action plan and implement on the ground as part of ‘R’ (response). Countries are struggling for nationwide coverage. Lack of human resources, dropout of volunteers, adequate orientation, community awareness, functional MPDSR committee analyse the findings and response immediately if key barriers they identified. Moreover, all countries mentioned strong collaboration, coordination and partnership are needed to accelerate the whole process; resource mobilisation is also necessary to scale up the community MPDSR in this region. • Almost all countries indicated the low coverage of community death notification which needs to be strengthened. Effective coordination, collaboration and commitment are critical and extensive advocacy is required to accelerate community death notification part. There is also limited capacity at community level which requires deliberate investment, and it is essential to have an active monitoring system. | <p>UNICEF, WHO, UNFPA, Maternal Perinatal Death Surveillance and Response Capacity Building: Case study of community identification of Maternal and Perinatal Death, Joint WHO/ UNFPA/UNICEF, 2018</p> |
| Bangladesh | |
| <ul style="list-style-type: none"> • There is still an under-utilisation of MPDSR findings and subsequently a lack of action taken in response. There are gaps in the quality monitoring of MPDSR at various levels. | <p>UNFPA Annual Report 2019 – Bangladesh, 2020, p.13</p> |
| National: Benin | |
| <p>Après huit années de mise en œuvre de la SDMR au Bénin, les indicateurs de la mortalité maternelle et néonatale stagnent malgré de nombreux efforts consentis à divers niveaux.</p> | <p>Rapport de la Réunion statutaire du comité national</p> |

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| <ul style="list-style-type: none"> Les notifications s'améliorent progressivement mais la qualité des audits demeure peu désirable et donne parfois l'impression que certains acteurs conduisent le processus d'audit juste comme une formalité. Des dysfonctionnements mal ou non identifiés aux recommandations mal formulées. | | | | | SDMR pour évaluer son fonctionnement, Septembre 2020 |
| Points forts de la SDMR <ul style="list-style-type: none"> Augmentation progressive du nombre d'audit de DM et DN réalisé Existence d'une ligne budgétaire dans le plan intégré de travail de certaines zones de santé, CHU (Centres hospitaliers universitaires) et CHD (centre Hospitalier Départementaux) pour organiser les séances d'audit. Accompagnement de la mise en œuvre dans certaines ZS de partenaires techniques et financiers. | | | | | Plaquette SDMR 2018 |
| Il existe une grande variation entre structures de santé CHD (Centre Hospitalier Départemental) et CHUs (Centre Hospitalier universitaire) et zones de santé : le taux de notification varie entre 29 et 100%, et le taux de réalisation entre 0 et 100% | | | | | Rapports SDMR Benin, 2018 et 2019 |
| Différentes valeurs sont présentées pour chaque indicateur, probablement parce que les données mettent du temps à être collectées et vérifiées. Tendances sont : <ul style="list-style-type: none"> Le taux de notification oscille autour de 50% (48-54 – TBC) Le taux de réalisation des audits : Besoin de confirmer chiffres pour évaluer si la tendance est à la hausse ou non) L'épidémie de Covid 19 a sévèrement impacté le taux de réalisation des audits (chutant à moins de 30%), mais pas le taux de notification – ce qui souligne que la notification est institutionnalisée | | | | | Rapport SDMR 2018 Rapport SDMR 2019 Rapport Annuel MHTF 2020 |
| Année | Nombre de décès notifiés | Taux de notification | Nombre d'audits | Taux d'audits | |
| 2017 | 714 | | | 49% | Rapport SDMR 2018 |
| 2018 | 860 753 | 48,6% 42,5% | 478 | 55,6% 46% | Rapport SDMR 2018 Rapport SDMR 2019 |
| 2019 | 1019 | 54,9% 48,6% | 475 | 43,3% 55,6% | Rapport SDMR 2019 Rapport Annuel MHTF 2020 |
| 2020 | | 50% | | 29,3% | Rapport Annuel MHTF 2020 |
| Résultats <ul style="list-style-type: none"> Les gens savent comment faire un audit et la qualité a augmenté la plupart du temps Les audits sont réalisés chaque semaine, programmés au niveau de la ZS et réalisés par l'équipe d'audit. Mais il manque l'appropriation par l'équipe CHUD | | | | | District Health staff, Mai 2021, Benin |
| Implication des sages-femmes dans la SDMR <ul style="list-style-type: none"> Mais parfois, les recommandations sont bien prises en compte. Il y a des sages-femmes qui restent motivées [par la SDMR], et bien elles le font sur le suivi de leur médecin chef. Dans un cas de décès que j'ai géré, il a été interdit à au centre de santé | | | | | Entretien sage-femme, Centre de santé, Mai 2021, Benin |

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| <p>[privé] de faire des accouchements, et moi je fais le suivi de cette recommandation. Toutes les deux semaines, je fais un tour, je fais mes enquêtes pour savoir si la décision est respectée.</p> <ul style="list-style-type: none"> ● Si on avait des cas, on devrait faire les audits ? Moi j'ai reçu la formation, mais je suis seule. Donc s'il y a un cas, ce serait à moi de l'instruire. Mais au niveau de la zone sanitaire, ce sont les gynécologues, la banque de sang, l'équipe de réanimation le cas échéant, la Responsable des soins obstétricaux, le DDS ou son représentant et le centre dont la femme vient. Il y a des recommandations mais elles ne sont pas souvent prises en compte. Le temps manque pour la RSO (Responsable des Services Obstétricaux) pour revenir dans le centre pour mettre l'accent sur ce qui a été dit. Donc tout dépend de la bonne volonté de la sage-femme dans le centre de santé. Elle est motivée, elle appliquera les recommandations. Sinon, elle ne les appliquera pas. Pour améliorer, il faut former toutes les sages-femmes et après la formation, il faut un délai pour la mise en œuvre de toutes les recommandations. Il ne faut pas qu'on formule les recommandations et que ce soit rangé dans les placards. ● Les recommandations ne sont pas mises en œuvre, parce qu'on ne prend pas la chose comme s'il s'agissait de nous-même. Aussi, il n'y a plus de per diem pour les audits. Comme par avant. Donc cela émousse certainement les ardeurs. Cet état de chose peut aussi expliquer la baisse d'intérêt du personnel pour les audits. | |
| <p>Problème de fond de la SDMR : Recherche des causes et redevabilité</p> <ul style="list-style-type: none"> ● La capacité à identifier les problèmes et la redevabilité sont limités : 5 conditions-clés pour assurer redevabilité : 1) clarification des attentes ; 2) principal a les capacités à mettre en œuvre ce qu'on lui demande 3) définir ensemble mesures, périodicité et feedback 4) conséquences (incl. félicitations) <p>Solutions</p> <ul style="list-style-type: none"> ● Intégrer les systèmes – financement de UNFPA (pour la réflexion) mais processus ralenti par changement de direction au ministère ● Les Rapports d'audits devraient se faire au niveau de la base – digitalisation (rapport sur email et envoyé) ● Module de formation sur l'identification des problèmes et cartographie des parties prenantes. Une série de formation prête à être mise en place ● Analyse aidée par UNFPA, mais UNFPA ne construit pas le laboratoire/ne financent pas les actions de suivi ; si MHTF apportait un peu plus, ça aiderait | <p>Entretien ONG IP</p> |
| <p>Recommandations : Certaines ne sont pas mises en œuvre par manque de moyens financiers, matériels et humains</p> | <p>Entretien, Département de la santé du district, Mai 2021, Benin</p> |
| <p>Tous les piliers du système de santé ont leur part de responsabilité dans la stagnation des indicateurs de santé maternelle et néonatale.</p> <ul style="list-style-type: none"> - La qualité des soins est liée aux compétences des prestataires et qu'il faut poursuivre les renforcements de capacités de ces derniers (surtout ceux provenant des structures de formations non étatiques). - La notification devrait être dissociée des revues qui quant à elles doivent être intimement liées aux recommandations. - La qualité des audits va de pair avec celle des auditeurs. Il faut donc veiller à la formation des membres des comités d'audits. | <p>Surveillance des Décès Maternels/Neonataux et Riposte (SDMR)</p> |

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| <p>Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal, and neonatal deaths in national and sub-national systems and increased implementation of responses</p> | |
| <p>- La redevabilité doit être remise au cœur de la SDMR aussi bien au niveau du comité national, que des comités infranationaux et des prestataires. Sanctionner les membres d'un comité d'audit où à diverses reprises les mêmes dysfonctionnements conduisent à différents décès a été une évoqué.</p> <p>- Il faut instituer des mécanismes de motivation comme par exemple la participation aux audits comme critère d'avancement professionnel. Il ne s'agit pas ici de motivation financière</p> <p>- L'intégration de la SDMR dans les curricula de formation pourrait être une approche intéressante.</p> | <p>Réunion statutaire du comité national SDMR pour évaluation de son fonctionnement Septembre 2020</p> |
| <p>Solutions :</p> <ul style="list-style-type: none"> ● Refaire l'analyse des parties prenantes : élaborer un bon répertoire des problèmes et des acteurs qui sont censés être impliqués dans la réponse aux problèmes - Le problème est souvent lié aux ressources humaines. Or, il n'y a pas de responsable des ressources humaines dans le comité national SDMR ● Opérationnaliser la redevabilité aussi bien du comité national que celui des autres comités et des prestataires en commençant par définir les axes de redevabilité ● Organiser des recherches dans les hôpitaux/régions, à remonter vers comité national – initiative de recherche dans 4 centres de santé pour analyser les pratiques et le contexte (par socio-anthropologue et sage-femme) y-compris évaluations des compétences des sage-femme (observations des sage-femme). Utiliser une approche systémique – au-delà des hôpitaux, quelles sont les barrières ? | <p>Entretien, ONG National, Mai 2021, Benin</p> |
| <p>National: Sudan</p> | |
| <p>Achievements</p> <ul style="list-style-type: none"> ● MDSR is now introduced [at national and state level] and focal persons network is fully established. MDSR is accepted and ongoing at national and states level, with regular notification, review, and regular national report with many interventions have been recommended and implemented. ● Good investment, particularly from relevant donors on midwifery training and FMOH and SMOH in recruiting midwives in health system to improve women health, however in-service training is poor. ● Management protocols for emergency obstetrics have been implemented but are poorly adhere to. | <p>UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018, UNFPA Khartoum.</p> |
| <p>MDSR activity</p> <ul style="list-style-type: none"> ● UP to the end of Q3 of 2020 UNFPA supported the notification and investigation of 703 maternal deaths. ● The national and state level MDSR committee meetings continued to function in 2020 but the regularity was affected by COVID-19 pandemic. ● Two zonal technical committees' meetings were conducted in Darfur zone (Alfashir) and Kordufan zone (Elfula); the third meeting is planned for the Eastern zone (Kassala). ● The 2019 MDSR report was finalized and disseminated in early 2020 to the key stakeholders. | <p>UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>Influx of vulnerable people affects coverage</p> <ul style="list-style-type: none"> ● Sudan has international borders with the nascent state of South Sudan. Reporting maternal deaths was a huge problem due to a lack of a properly functioning information system. Although the work of MDR in White Nile State started in 2009, it was not possible for it to cover all of White Nile State due to lack of resources. | <p>UNFPA, Summary report on the use of mobile phones, 2017, UNFPA, Khartoum, Sudan</p> |

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| <p>UNFPA support to MPDSR</p> <ul style="list-style-type: none"> ● UNFPA supported the MPDSR process with support to: Regular meetings of the technical committee. <ul style="list-style-type: none"> ○ All meetings of technical committees are supported by UNFPA in addition to notification and investigation of cases at both community and health facility level. These are quarterly and annual. ○ Notification and investigation activities although financial support to investigations at community level is limited. ○ Technical support to the programme through expert consultant is “well-appreciated” by FMOH. ○ UNFPA also supports capacity building programmes at both federal and state levels to help identify the MPDSR model and approach and to improve reporting, the review process and monitoring. However, capacity building in the FMOH team is yet to be completed. | <p>Interview, RH Team, FMOH, Khartoum, Sudan, 1 June 2021</p> |
| <p>MPDSR reporting in Blue Nile State</p> <ul style="list-style-type: none"> ● Regular weekly meetings are conducted to review the performance and outcomes of the week including discussing maternal deaths and ruling out whether and how these were avoidable. “Then we raise regular reports to SMOH”. | <p>Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021</p> |
| <p>At the maternity referral hospital</p> <ul style="list-style-type: none"> ● The hospital has a maternal death committee that meets regularly and is responsible for investigation of any maternal death. ● This supports the hospital to understand the main causes of maternal death and then to take action, develop plans and procedures to avoid similar deaths in the future. ● Large staff turnover so same points come up repeatedly. | <p>Interview, Referral Hospital Medical Director, Sudan, 5 June 2021</p> |
| <p>Leveraging more partners to become engaged in MPDSR</p> <ul style="list-style-type: none"> ● It was firstly called MDR and was fully supported only by UNFPA. As the programme showed good impact and more potential for expansion appeared, other organisations were involved including WHO and UNICEF, which have a technical role now in the technical committees. | <p>Interview, UN Partner, 9 June 2021, Khartoum</p> |
| <p>MPDSR: Role of UNFPA</p> <ul style="list-style-type: none"> ● UNFPA supports the quarterly and annual meetings of the technical committees. ● Also, UNFPA supports investigation of cases at both community and health facility level. <p>Main issues facing the programme</p> <ul style="list-style-type: none"> ● Payment of community-based investigation is limited although supported by UNFPA. ● Consistent reporting at the State level/district level. <p>Partners</p> <ul style="list-style-type: none"> ● It is mainly by government and UNFPA funded with limited contribution of UNICEF. ● UNICEF and WHO offer technical support and guidance. | <p>Interview, SMOH, Ad Damazin, Blue Nile, Sudan, 7 June 2021</p> |
| <p>Impact of MPDSR</p> <ul style="list-style-type: none"> ● Involved in driving implementation of MDSR in Sudan including the FMOH, SMOH, and supporting partners particularly UNICEF, WHO, Sudan Society of Obstetricians and Gynaecologists, doctors, midwives and national NGOs/CSOs. All played important roles in technical support, data collection, SMDRC meetings without personal remuneration for their participation. | <p>UNFPA, Sudan Maternal Death Surveillance and Response Annual Report, UNFPA Khartoum, 2018. p.7</p> |

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| <ul style="list-style-type: none"> Many states demonstrated good reduction in MMR compared to previous reports, which might be due to managerial commitment and personal interest in reducing MMR [by individuals]. These interventions have led to improved quality of care through mobilization of additional resources, including training of midwives, availing of clean delivery kits, theatre equipment, equipped and functioning ambulances and essential drugs for emergency obstetrics problems. | |
| <p>Challenges</p> <ul style="list-style-type: none"> MDSR is not institutionalized in the health system, with weak response in implementing actions to recommendation. High turnover of MDSR trained staff members, poor record keeping at all levels of care and poor supportive supervision at the states. There is lack of legal framework for regulation of MDSR and fear of blame with absence of financial support, capacity development, and adequate community engagement, many competing priorities in health system, inadequate leadership, and follow up of recommendations. <p>Recommendations</p> <ol style="list-style-type: none"> Scaling up of notification and identification of maternal death by focal persons at institutes and home, midwives are to be strengthened for reporting of maternal and neonatal deaths at both hospitals and home. A one-day short reminder workshop for each state, including all stakeholders and participants on how to notify and record. Strengthening state supervision for midwives and focal persons. Improving interpretation of analysed maternal death by strong commitment of SMDRC for regular meeting and response to every maternal death. Strengthen referral system by midwives and medical officers with strict criteria for hospital delivery and refer for hospital delivery in ample time, using tel. communication before referral. Strengthen utilization and adherence to management protocols at all levels with strict criteria for monitoring adoption of protocols and availing of requirements for implementation through adequate political commitment and support, adequate human and financial resources and proper stakeholder’s participation. Improve implementation and monitoring of recommended interventions. Design and endorse legal framework for MDSR, for mandatory maternal death notification and review, and information gained are not for litigation. | <p>UNFPA, Sudan, Maternal Death Surveillance and Response Annual Report, UNFPA Khartoum, 2019. p.9</p> |
| <ul style="list-style-type: none"> UNFPA funded a technical position to support the coordination of MPDSR. A technical working group meets regularly, and all interested/engaged partners are there. The quality of the identified technical staff is not always what they should be to ensure maximum effectiveness and impact of the programme. In this case, the Technical Working Group, chaired by FMOH, will decide to terminate a contract and seek other candidates. This has happened once. “That person and the system under them were not running in an efficient way”. A new consultant was brought on board agreed by the whole Technical Working Group. Although their performance is better the RH team is still working on adjusting the direction of development. The Working Group will soon make a recommendation about, but it is for FMOH to decide whether they want to proceed. | <p>Interview, RH Team, UNFPA CO Khartoum, 17 June 2021</p> |
| <p>Togo</p> | |

| Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal, and neonatal deaths in national and sub-national systems and increased implementation of responses | |
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| <ul style="list-style-type: none"> ● SDMR II en est de même pour la surveillance des décès maternels. La SDMR est soutenue aussi bien par l'UNFPA que par l'OMS. Par rapport à l'UNFPA, les activités d'appuis sont surtout l'appui à la mise en œuvre des surveillances des décès maternels dans les structures de soins. Il y a les activités de suivi et accompagnement des équipes formés à la surveillance des décès maternels. | MoH staff, 2021, Togo |
| <ul style="list-style-type: none"> ● MDSR : La Surveillance des décès maternels, du nouveau-né et riposte a été rendue effective à travers des revues des décès maternels et néonataux organisées avec l'appui des autres partenaires (UNFPA, OMS, AFD Muskoka). Au total 34% des décès maternels survenus dans les SONU ont été audités, selon le monitoring du semestre 1 de 2019. | UNFPA, Template For Maternelle Health Thematic Fund Reporting, 2019 |
| <ul style="list-style-type: none"> ● Little progress was made on midwifery and MPDSR. If for the first strategy, oriented actions are due to enhanced quality of pre-service training through accreditation and the attention to be paid on health facilities for student internship in the MPDSR side, a committee to supervise the control of maternal death should be set up, then maternal death audit conducting should be transferred to external entities to services providers. | UNFPA, 2018 Template for Country Annual Joint Reporting for The MHTF and Joint Programmes, Togo |
| <ul style="list-style-type: none"> ● Taskforces from three regions out of six, have received a supervision from trainers on MPDSR, in order to dynamize them. The activities were supported together with the Muskoka-funded project led by Agence Française de Développement (AFD) and the UNFPA programme. | UNFPA, 2018 Template for Country Annual Joint Reporting for The MHTF and Joint Programmes, Togo |
| <ul style="list-style-type: none"> ● In Togo: COVID-19 sensitisation and prevention campaign, bleach production, opening a SGBV centre in the BEmONC in Adidogomé (Maritime region), coach the six midwives newly deployed in three BEmONC facilities in Maritime, and partner with the national Obstetrics and Gynaecology society to assess bottlenecks in the maternal death notifications and reviews. | UNFPA and Takeda, Global CSR Progress Report, Togo 2020 |
| <ul style="list-style-type: none"> ● Par ailleurs, la stratégie de la SDMR a besoin d'être appropriée par les acteurs locaux et il faut un système de veille nationale sur la question des décès maternels, pouvant passer par le partage régulier d'information et la réflexion d'ensemble sur les solutions à apporter. La qualité de la formation des Sages-Femmes doit passer par une accréditation des écoles de formation et des sites de stage. | UNFPA, MHTF Request Proposal 2019-2022, 2019 |
| <ul style="list-style-type: none"> ● For example, the case fatality rate from direct obstetric complications managed in EmONC health facilities is four per cent in Togo compared to the maximum recommended norm of one per cent. Reviews of maternal deaths are critical to improve quality of care, yet only one third of maternal deaths in EmONC health facilities are reviewed in Togo. | The MHTF UNFPA, Annual Report 2019, 2020, Togo |
| Uganda | |
| <p>Reported progress/challenges in 2018</p> <p>During FY 2018/19, the MoH conducted the following MPDSR activities as part of the national response:</p> <ul style="list-style-type: none"> ● Provided MPDSR feedback and mentorship at the beginning of FY18/19. ● Held Parliamentary meetings with the Parliamentary Committee on Health. ● Conducted data spot checks. ● Revised MPDSR Tools to align with the requirements in HMIS. ● Provided monthly updates in the MCH Technical Working group. ● Strengthened the perinatal component; with support from UNICEF, conducted a national PDSR Training of Trainers aimed at improving regular reviews of perinatal deaths. Sixty-five (65) TOTs were trained. | MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response Report 2017/1, 2019 |

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The report noted that, in general, technical support supervision provided by district MPDSR committees to health facilities was inadequate. Reasons for this included:

- Some districts **do not perceive MPDSR as a priority** except when there are partner-funded, focused programmes
- Limited integration of MPDSR in workplans
- Inadequate involvement of district leadership
- DHTs **not sharing reports** with political leaders
- MPDSR is **led by nurses/midwives** and not doctors
- **Lack of feedback** to/from referring facilities
- Inadequate support from supervising referral hospitals
- **Multiple avoidable factors led to maternal deaths**, i.e., low numbers of health service providers at delivery points; low skills in EmONC; poor referral mechanisms; fear among health workers to handle high risk mother; lack of fuel for ambulance(s); and lack of blood and blood products.
- It was observed that some health facilities **fear to report maternal/perinatal deaths** as they fear reprimand from district leaders, politicians and/or the police. Sometimes, next of kin are told to take away the deceased without any record of having attended the health facility. Cases of perinatal death are misreported as abortions or as a child death.
- Some of the approaches used include conducting monthly reviews of maternal deaths by in-charges and DHOs, follow-up phone calls to sites with maternal deaths; reporting via personal mobile phones using WhatsApp; streamlining the review process, etc.
- **Regional efforts to address these gaps included** on-site mentorship of CEmONC facility teams, implementation of quality improvement projects aimed at reducing facility delays accessing emergency obstetric care. USAID supported procurement of MNCH equipment such as BP machines, resuscitation equipment, thermometers, and delivery kits to USAID/RHITES supported districts.
- **In 2017/18, over 1,100 maternal deaths were recorded** in the HMIS. Of these approximately one-half (49 per cent) were notified and 47.5 per cent were reviewed. This represents an increase from 2016/17 in which 27 per cent were notified and 27 per cent were reviewed. This improvement is attributed to training of providers in MPDSR.
- **A total of 131 out of the 134 (97.8 per cent) districts in the country are notifying maternal and perinatal deaths** through the DHIS-2. However, out of the total number of districts that notified maternal deaths, only 76 (58 per cent) carried out reviews. Introduction of results-based financing (RBF) through the World Bank may be used as an innovation to support committee functionality.
- **Maternal death notification increased from 50 per cent in FY 2017/18 to 58.5 per cent in FY 2018/19.** (National HSDP target = 85 per cent.) The increase is attributed to revitalization and formation of MPDSR committees, training of health workers and HMIS records officers on MPDSR reporting and data management and increased awareness on use of MPDSR as a quality improvement tool for mitigating occurrence of maternal death among stakeholders.
- There was an **increase in perinatal death reviews** from 8 per cent in Q1 to 34 per cent in Q4.

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| <ul style="list-style-type: none"> ● In 2018, UNFPA reported “slight improvement” in functionality of MPDSR system at national, district and facility levels. Several reasons are cited to explain the low proportion of deaths that are reviewed including, poor records management, especially at lower facility levels, mixing of death files with others making it difficult to retrieve the files, stock-out of MPDR tools, lack of critical staff with capacity to analyse causes of death and lack of incentives for MPDSR committees, hence non-functional committees at facility level. ● Others include non-functional response system which demoralizes the committees as the process is seen as a waste of time. All these areas have been identified to improve action for result based programming. Collection, analysis and writing of the annual MPDSR report is in progress. UNFPA continues to support compilation and reporting of annual MPDSR reports at both district and national levels to ensure continued quality improvement. | UNFPA Uganda. 2018 MHTF Annual Report. 2018 |
| <p>Recommendations identified 2018</p> <ul style="list-style-type: none"> ● Hold regular national, regional and district MPDSR committee meetings and on-site support ● Roll out newborn register and perinatal death notification form ● Functionalize newborn care units at HCIV facilities and hospitals with special allocation of staff to neonatal units including a medical officer at district and RRH. | MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response Report FY 2018/2019, 2019 |
| <p>Reported progress/challenges in 2019</p> <ul style="list-style-type: none"> ● In Q3, UNFPA supported a select team of the MoH National MPDSR committee to analyse and draft the Annual MPDSR report through a process of collection, compilation, and entry of data on Maternal and Perinatal death reviews into the e-HMIS. The Final Draft report was submitted to the National Committee for Validation and Presentation to the MCH cluster and Senior Management Team for adoption in October 2019. Concept notes were written for the development of an electronic tool to track MPDSR implementation at Sub-national level and for the Development of the Costed National Implementation Plan; both are awaiting approval and availability of funding from UNFPA. ● In Q4, the Draft Monitoring Tool for Tracking Implementation of MPDSR at National and Sub-national level was developed, with plans for pre-testing in 2020. MoH developed a Draft National Implementation Plan for MPDSR which will be costed in 2020. | UNFPA Uganda, GoU/UNFPA Country Program Support to MoH 2019 Annual Workplan, 2019 |
| <p>Findings from 2020 MPDSR reviews:</p> <ul style="list-style-type: none"> ● Inadequate supply of uterotonic drugs (Pitocin), MgSO4 at the district hospitals, and lower units (can be avoided by increasing stocks during the quantification process as orders are compiled). ● Poor referral systems due to lack of means of transport and some districts lack ambulances to transport emergencies. ● Delay to decide by the patient and the family to go to a nearby facility for safe deliveries, some mothers go to traditional birth attendants where they are delayed and are brought in poor condition, others delay at home due to cultural beliefs, knowledge gap, poor male involvement, etc. ● Knowledge gap on obstetrical emergencies among health workers and do not follow provided protocols and SOPs, e.g., partographs filled out after delivery, labour monitoring was informal. | MoH Uganda. The National Annual Maternal and Perinatal Death Surveillance and Response. 2020. |

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| <ul style="list-style-type: none"> ● A range of challenges to implement recommendations at facility level were noted. Among them are: stockouts of essential medicines, insufficient HMIS tools, high turnover of staff, limited funding, poor provider attitudes (no incentives), lack of power/no generators at CEmONC and BEmONC facilities, knowledge and skills gaps, internet connectivity, etc. | |
| <p>Recommendations/best practices resulting from 2020 MPDSR review</p> <ul style="list-style-type: none"> ● General summary recommendations made from the maternal and perinatal death reviews at facilities: ● Strengthen health provider skills and knowledge through training, mentorship, CMEs, and supportive supervision to address addressing knowledge gaps in areas of EmONC and HBB. ● Improve on number of staffing (doctors & midwives) through recruiting critical cadre staff, set up a neonatal resuscitation team, etc. ● Equip health facilities with equipment such as monitors, better operation tables, provision of adequate lighting in the theatre. ● Ensure a constant blood supply and other products like fresh frozen plasma and platelets. ● Improve the supply of EmONC drugs and supplies. ● Encourage mothers to attend ANC for early identification of risky conditions. ● Improve documentation. ● The report identified best practices in MPDSR implementation by highlighting a case where the MPDSR cycle was completed. This included conducting death reviews at facilities from where the mother was delayed. This requires a committed team of health workers who emphasize the principle of (no name, no blame) so that the health workers can tell the truth and hence develop actionable recommendations at the end. It is important to give positive feedback to the referring facilities together with the district officials to improve systems and care. | MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response. 2020 |
| <p>UNFPA inputs to follow-up MPDSR findings</p> <ul style="list-style-type: none"> ● “UNFPA also supported Kawempe NRH and Kampala Capital City Authority (KCCA) to identify facilities that were the hotspots for maternal and perinatal deaths in the Kampala metropolitan area. Kawempe NRH offered technical support to all these facilities in identifying quality care gaps and addressing them. The aim of this support is to reduce on unnecessary referrals as well as maternal and perinatal deaths. Joint technical visits to other referral hospitals (Mulago Women’s hospital and China Uganda Hospital-Naguru) in the city have decongested Kawempe NRH by strengthening collaboration and joint responses for CEmONC services. (p.7) ● UNFPA supported the MoH National MPDSR committee to compile the Annual MPDSR report 2019/20. Key Analysis and Observation of the report have been incorporated into the national health sector performance report 2020 and validated by the MCH cluster.” (p.7) ● Maternal death notification increased from 59 to 76 per cent between 2019 and 2020. Reviews increased from 51 to 66 per cent in the same period. ● CHAI and USAID supported the MoH to carry our facility-based mentorships to build capacity of health workers and facility committees on MPDSR, including reviewing deaths and supporting data input to HMIS. | UNFPA Uganda, Final Annual Report for MHTF, 2020 |
| Improved processes lead to increased motivation and problem-solving | Interview, UNFPA Uganda national staff, May 2021 |

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- There is a weekly platform (**weekly MPDSR and PPH platform**) where deaths are identified at national level. It is chaired by the Assistant Commissioner for Reproductive and Infant (R&I) Health and includes champions from academia, IPs, RRH representatives. When the deaths are reviewed, the group tries to find the common issues, and then works with partners to reach out to the facilities. **This motivates the referral sites and health workers** – they know that the reviews/reports will be looked at and action taken – and support given to solve the issues, so that motivates them to continue the reviews. These meetings started March this year.
- UNFPA plays a role in the meeting by providing technical input. **UNFPA provided technical support and funded the costing of the PPH national framework.** UNFPA also support the extension to the Regional Referral Hospitals (RRH) – to functionalise their regional MPDSRT committees (Hoima region and West Nile).
- With **funding from Sida, UNFPA supports capacity building** in a number of districts on MPDSR, especially to support quality reviews, notification, reporting.
- UNFPA also supported KAWEMPE national hospital and the Mulago Women and Neonatal specialised clinic to improve their MPDSR process – and the quality improvements in terms of quality of care. “We have also supported them to provide axillary support to the referring facilities around Kampala. We have **supported Mulago and Kawempe to go and do mentorship and build the capacity** at their level – for the reasons for which they have been referred – we mapped the facilities that refer to Kawempe and Mulago – and the reasons for referrals – UNFPA supported the national teams to go and **do problem-based quality improvement** and support through mentorship.” The objective was to have those facilities have enough capacity to deal with their issue themselves. There **were many fresh stillbirths at Kawempe, because they were overloaded, and referred.** “We felt that many of the cases should be handled at that lower level (CEmONC sites – and some selected BEmONC) - they focused on the General Hospitals and HCVI (but added some few HCII). That was UNFPA funding – the national teams going to those referring hospitals to fill the skills gap – the main funding was Sida and MHTF – though we continue to incorporate other aspects.”

Challenges in implementation of MPDSR

- While the MPDSR policy and structures are very clear, the challenge is the implementation of the policy and action points. **The main issue is the non-response to the “national action recommendations” – from the lower levels.** Action points coming from facility level reviews are often not implemented – and that demotivates the facility to do the reviews. If the district level MPDSR is not able to respond to the recommendations/action points – supporting the facilities to rectify the issues (solve the problems) – if the district committee is not functional and not supportive of the facilities – the facilities will lose interest. Sometimes the district does not have the funding. **The motivation dies when there is no action.**
- **“At national level, referrals and the blood have been huge issues.** We have now tried to work on a referral system, so there are more systematic referrals. It is under conceptualisation – we have created an emergency medicines department – and one of the objectives is how to improve emergency services (and referrals) including the maternal/neonatal emergencies.”
- In the beginning, there was more “punitive action” – blaming the health facilities, so health workers withdrew. “Since then, we have **emphasised the “no blame game”, that the objective is learning.** There is a lot of attitude change at facility level regarding these reviews. In 2016-2017, they would not review, not report, of cause of fear. They would not report the deaths.

Interview, UNFPA Uganda national staff, May 2021

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Making the whole thing being on the head on the health workers, discouraged them. It is changing now, although we still have cases of where they are hesitant to report death and review, but there has generally been a positive change over time. Also, whenever we publish the reports, IPs and other support the process. The National level also does “confidential inquiries” – they are not just information picking – but also to support capacity building.”

District/service delivery perspectives on MPDSR

- **Marie Stopes Uganda (MSU) aims to build capacity of DHO and health facility staff to strengthen MPDSR structures and processes;** however, this is in the initial stages. There are initial challenges with following up on actions/recommendations from the MPDSR review meetings due to lack of funding/transportation to involve lower level referring facilities where the delays/issues often start. To overcome this challenge, MSU is providing support to facilitate their participation/transportation. The interviewee noted that the action points seem to be followed up, mainly through mainly through mentorship and supervision.

Interview, NGO national partner staff, Arua District, Uganda, May 2021

- MPDSR started in the district around 2015/2016, when first MoH guideline was received. MPDSR is a quality improvement intervention under MoH, with a policy guideline to support it. **Districts are mandated to conduct MPDSR. However, health practitioners have been slow to embrace it.** Partners have identified it as a strategy that can be a game changer in addressing maternal health, therefore they are supporting districts to strengthen that system.
- “Marie Stopes has provided us with some support. But they are not the first, AVSI had already started supporting us in this area before. We also had a USAID-partner, ASSIST, in 2014-2015. Even RHITES North-Acholi also supported us in MPDSR, starting in 2017-2018, but they are not really active in maternal health.”
- At the moment, **Marie Stopes supports the facility-based review meetings.** The most important step in MPDSR is the problem identification – or identify that intervention (good practice) to prevent a death. So, Marie Stopes works with the **DHO to identify “resource persons” with good skills – and Marie Stope supports that “resource person”– to become mentors** for the MPDSR – and go support reviews at facilities.
- In 2018, a team of four staff from DHO (including the ADHO, but not the DHO) received a 5-day training of trainers (ToT) on MPDSR – took place in Gulu – it was conducted by MoH with support from USAID.
- At the moment, Marie Stopes is not doing any ToT, and they just started. In time, a refresher training is needed for existing trainers and to add new trainers for MPDSR. Lawmo is a large district, and the 4 DHO staff trained on MPDSR is not enough, they cannot cover the entire district, especially since MPDSR is not their only responsibility. If every HC III or HC VI had one trained person in MPDSR – to support others, it would be very good.
- MPDSR is still in its infant stages in our districts.
- Death notifications have increased over time. But to ensure sustained increase, **more training/capacity building is needed to consolidate and sustain efforts.** Guidelines and tools have helped.
- The **timeliness of the committees at the facilities to sit and audit an occurrence still needs improvement.** When an instance occurs, the committee sits, but not always within 24 hours. Sometimes they delay and sit only within 48 or 72 hours – but it would be good to sit immediately – even if not everyone can be there right away – because it is an opportunity for you to learn, take action, and do something differently.

Interview, MoH staff, Lawmo District, Uganda, May 2021

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- “When MoH introduced MPDSR into the system, in the beginning, the way it was brought and being enforced by the MoH, it appeared as if **it was a “fault finding intervention.”** So somehow, many health workers retracted. You can imagine, at that point, if a mother died, the committee sat down, identified that the doctor who should have done operation, was not available, therefore the recommendation is “doctor should be more available” – report would be sent to MoH, with a monitoring done by the president’s office – they would follow-up on the case and arrest and prosecute the doctor. So, it appeared to be a punitive intervention. When the MoH realised that they started changing the approach. That made it difficult for health facilities to immediately report, because you would be considering, if I report, how safe will I be? HCW did not feel safe of the consequences when they reported. But it is changing, because all of us realise that moving in that direction will not help.
- During that time, reporting was so low, HCW would keep quiet. So moving forward, we need to show HCW that when they report, we support them in removing the challenges, not punishing them. We identify the challenges, e.g. if the commodity (e.g. misoprostol etc.) was lacking, and that was the reason for the bleeding/death, then we should help solve that problem. If the team reports that there was a challenge in the community, e.g. the first delay contributed to the fresh stillbirth, when this is brought to our attention, at DHO level, we should support the facilities to go to the community to talk with them.
- I think if we, DHO, show our facilities/providers that we are there to support them, they will be more comfortable supporting. When we have seen an increase in notifications and reviews, it is because **we DHO look at it that way – as a supportive intervention, not punitive.** In some places, there is an issue, and we need to take disciplinary action – or we place a senior person to support someone with skills lack.”
- **Timeliness of the review – and the reporting of the cases to the DHO – can be improved** if they feel confident and comfortable that “if I report, I will get support, not punishment”. That should be very clear in all messages to the health workers. “Learning is a continuous process, and sometimes you learn in the hard way.”

- The interviewee attended a district-level one-day orientation to MPDSR in 2018. **Reviews are conducted when deaths occur** by a committee; **there are no regular meetings.** The in-charge does not always participate. When a death occurs, the MCH use the notification form to review the case and submit it for the record. ☒

MoH staff, Lawmo District, Uganda, May 2021

- **In Gulu district,** UNFPA supported the MPDSR process by **training DHT and Health Unit Management Committees (HUMC)** at the facility level and supporting MPDSR processes in three selected health facilities. UNFPA used MoH national and regional MDPSR trainers for those trainings.
- UNFPA support to training in MPDSR reviews has **improved on auditing and giving the notification form from facilities to the district.** The DHO team goes to work with the facility teams to identify the root cause of the death. However, the **main challenge is having funds for inviting the staff from the lower-level facilities** (who referred the woman to a higher-level facility) to participate in the MPDSR meetings, or from the health teams to travel to these lower-level facilities. Same issue seen in one of the facilities visited in Lamwo district. Also, the DHO stated that **notification of community deaths is still a major challenge.**

MoH, Gulu District, Uganda, May 2021

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- UNFPA trained the DHT team. As DHTs, we then go to provide **mentorship and support sites/facilities**. UNFPA did not conduct the Training of Regional Trainers/Mentors, that is the national MoH trainers (funded by UNFPA), but they (UNFPA) come to supervise the ToT training at the district level.
- UNFPA also supported the DHO quarterly review meetings (general, covering the entire annual work plan of the DHO, including MPDRST, HIV etc.) Even before that, there was a training for the Health Unit Management Committees – trained by us, the DHO. **UNFPA joins for the quarterly review meetings at district level, and also for the MDRs in the three facility sites** – or when they do supportive supervision, to see what we do in the MPDSRT Review Meeting. There was also a representative from MoH – Sister Agnes – to assist with the last death review meeting in St. Maurice Hospital (Gulu town).
- To ensure a quality MPDSR process, the DHO sits with the health care providers and HUMC members to look at the **partographs and the registers – to see the quality of what has been documented**. Problems are identified jointly with the facility staff, and reviews are conducted of what essential medicines were used, how was it administered, at what time was it done, the community representative was always there.
- **The notification is still minimum – a lot of community deaths occur without notification**. If a hospital has 12 deliveries in one night, there is a death, but it can take up to seven days before the death is audited – because the committees need to sit and verify. If it takes seven days to sit down and discuss, it will come late to our district office, but it has to be done within seven days. **The process is as follows:**
 - Internal audit/review at the facility
 - Notification of death to the district should happen within seven days (they do not notify immediately – only every seven days)
 - Then the DHT goes and review together with the facility – we go to tease out what has been done right, what has not been done right. “We ALWAYS go – even without resources. But ad, there should be refreshments etc. especially for the community representatives.”
 - Facility staff, DHT staff, community representative – the HUMC (internal). The DHT picks the people to go and review. There are a lot of referrals in – as stated early on, Gulu is picking patients from other districts who are already in a critical stage.
- **Results-Based Financing (RBF) has really helped with supporting quality services** – because RBF incentives are improving provider motivation and performance. The indicators are better after receiving the RBF payment. RBF is coming to the second year now – it goes to HC II and VI – not yet the hospitals.
- **UNFPA also provides funds to train Health Unit Management Committees (HUMC)**. “We received the last financial report in March, waiting for our next disbursement – still waiting for the accountability. We had a lot of deaths which were not reviewed (during the lockdown period), identified by the MoH. In Gulu, we have a referral hospital, getting referrals from many surrounding districts/regions (Acholi, West Nile, Lango, part of Kiriadongo) – so we have (had?) many deaths. We started receiving support from UNFPA late 2020, we started implementing early this year.”
- But other partners are doing the same (MPDSR) – **UNICEF is doing a similar activity in MPDSR** but covering the entire district, HC III and VI - is open for all facilities in the district. UNFPA focuses only on 3 sites (i.e. health facilities) – UNICEF covers the

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other health facilities. UNICEF started supporting MPDSR this year. Before, they were more focused on HIV, but when the DHO raised the issue of high number of maternal deaths, UNICEF listened. “We said to UNICEF, can we please do more on dialogue/sensitisation of the communities on the importance on facility deliveries – using the HIV and TB funding.”

- “We need more UNFPA support for MPDRS – they only support 3 facilities (2 in town, 1 in the district) – we need **funds for DSA to travel** there for the day. If a death occurs at one of these three facilities, we sometimes need to go to the lower facility that referred the patient – but we do not have the funds to do so.”
 - **WHO also supports supportive supervision and surveillance** – there is a WHO team based here in Gulu – they participate in MDRs. “Surveillance was limping during COVID-19, WHO came to strengthen us.”

- **UNFPA provides support to DHOs to conduct MPDSR meetings.** “We request that the DHO also report to us any incident that happens. They hold immediate review meetings – and they generate action points. And they have to follow-up on those action points. For example, they must go to the community or facility to follow-up. So, we support the follow-up on those action points. We use the ADHO and the two district trainers/mentors – we facilitate their transportation/DSA etc. to do the follow-up.” **The main challenges are with the follow-up of the action plans, as they DHOs often lack support.** UNFPA “facilitates” (i.e., funds) some follow-up such as transport and DSA. Staff at lower levels need to be empowered to implement action plans. DHO has a budget for follow-up visits through Primary Health Care Grants, but it is inadequate. **They must work within government structures and the limitations of government budgets.**

Interview, UNFPA Uganda national staff, May 2021

Zambia

MPDSR results

- “The **CO provided technical support to MoH MPDSR processes including participation in weekly review of maternal and perinatal deaths, identification of factors contributing to the deaths. This has resulted in other provinces reducing maternal deaths.** For example, Western Province reported 69 maternal deaths in 2019 and have reported 44 in 2020. In 2021 UNFPA will support the national and subnational level to develop annual MPDSR reports. **The country is now ready for another step in MPDSR to start conducting Confidential Enquiries into Maternal Deaths (CEMD). Consultations are being made particularly with South Africa on how to start this process which will be supported by UNFPA in 2021.** The CO has continued to provide technical support for national MPDSR team to participate in virtual MPDSR regional meetings for capacity development and sharing best practices.

UNFPA, Zambia. MHTF Annual Report, 2020. Undated. p.5

Assumption 3.3: MHTF has fostered strengthened reporting and operational research in ways that support quality and service delivery improvements resulting from the implementation of MPDSR notification, review and response

Indicators:

- **Annual MPDSR report is completed and published**
- **Examples of impact where possible and range of consequences emanating from MPDSR death audits in target areas including on procedures, review and audit practices, approaches to addressing maternal death in health facilities and in communities.**
- **Records of MPDSRs that show evidence of conforming to national standards, are comprehensive and use national tools**
- **Number of peer reviewed MPDSR publications**

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| Assumption 3.3: MHTF has fostered strengthened reporting and operational research in ways that support quality and service delivery improvements resulting from the implementation of MPDSR notification, review and response | |
| <ul style="list-style-type: none"> ● Availability and credibility of plans to sustain (institutionalize) UNFPA-supported MPDSR within community and health systems ● Establishment of training, mentoring or QI programmes that support implementation of recommendations resulting from MPDSR assessments ● Results of death audits that are meaningful, actionable, and verifiable in terms of QI, systems or policy strengthening, or process changes ● Examples of community engagement or participation in MPDSR as critical stakeholders linked to the first two “delays” (delayed decision to seek care, delay reaching care) ● Examples – if any – of negative consequences from death audits and whether and how UNFPA supported the response and recovery from these. | |
| Observations | Sources of evidence |
| <ul style="list-style-type: none"> ● COs could focus more closely on a limited number of technical areas. However, at the same time, it seems evident from our exposure to some countries that there is a tendency for the four teams to be somewhat siloed from each other and this wastes resources and expertise. This seems to happen with MPDSR which is separated from systems, education processes, EmONC network at least in the countries I am familiar with. So the MPDSR was not integrated into the system and was treated as standalone. Not surprising it has not really worked. | Interview, Global Funding Partner, July 2021 |
| Bangladesh | |
| <ul style="list-style-type: none"> ● MPDSR: There remains a lack of reporting of ALL maternal and perinatal deaths. | UNFPA, Annual Report 2019 – Bangladesh, 2020, p.12 |
| <ul style="list-style-type: none"> ● The number of maternal deaths reviewed to identify causes and drive improvements also increased in 2018. Reviews in 12 countries covered more than 20 per cent of the estimated number of maternal deaths. Three countries reviewed at least 50 per cent of the estimated maternal deaths (Bangladesh, Ethiopia and Timor-Leste). | The MHTF UNFPA, Annual Report 2018, 2019, p.13 |
| Benin | |
| <ul style="list-style-type: none"> ● Nous savons qu'il y a des insuffisances ; par exemple une sous notification pour différentes raisons. Par exemple, certains ont peur qu'on les rende responsable du décès alors que la femme est venue mourir au portail (décès à l'admission). ● Pour les audits qualité, on descend et on constate que certains ne déclarent pas tout ou on déclare ce qui ne devrait pas être. Donc, la notification n'est pas toujours fidèle. Il n'y a pas de système de notification communautaire donc les décès communautaires échappent totalement à notre système. Contrairement à Tanguiéta qui dispose d'un système communautaire qu'ils appellent système sentinelle | Entretien Personnel de santé du district, Mai 2021, Benin |
| Sudan | |
| Reporting summary identifies majority of reported deaths happened in hospital | |
| <ul style="list-style-type: none"> ● Maternal deaths from obstetric haemorrhage were 471 (37.2 per cent); mainly PPH 330 (70.4 per cent) due to uterine atonia 40.1 per cent, retained placenta or retained products 10.8 per cent and ruptured uterus 18.3 per cent. ● Only 167 (34.5%) presented with bleeding, the rest developed bleeding inside hospitals. ● One third (34.0%) died at home, 124 (26.3%) were seen by senior consultants, 164 (34.8%) received blood. ● Failure of transfusion was due to unavailability of blood 260 (55.2%), and no ICU in 246 (52.2%). | UNFPA, Sudan Maternal Death Surveillance and Response Annual Report, UNFPA Khartoum, 2018. p.3 |
| UNFPA assistance supports regularity of meetings and reporting | |
| UNFPA, MHTF Mid-Year report for 2020, UNFPA, Khartoum, Sudan, 2020 | |

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| Assumption 3.3: MHTF has fostered strengthened reporting and operational research in ways that support quality and service delivery improvements resulting from the implementation of MPDSR notification, review and response | |
| <ul style="list-style-type: none"> ● Support to the implementation of MPDSR at national and states level through support for notification, review, responses and MPDSR committee meetings. This activity is continuous throughout the year and is progressing as planned. Support for the development of the MPDSR annual report. | |
| <p>FMoH confirms UNFPA support to reporting</p> <ul style="list-style-type: none"> ● The technical committee meets regularly (several external partners are present including WHO and UNICEF) but FMoH does not yet have sufficient capacity to deliver the MPDSR without technical assistance from UNFPA. ● All meetings of technical committees are supported by UNFPA in addition to notification and investigation of cases at both community and health facility level. These are quarterly and annual. ● UNFPA also supports capacity building programmes at both federal and state levels to help identify the MPDSR model and approach and to improve reporting, the review process and monitoring. | <p>Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021</p> |
| <p>Institutionalization of MDR in Blue Nile State</p> <ul style="list-style-type: none"> ● Regular weekly meetings are conducted to review the performance and outcomes of the week including discussing maternal deaths and ruling out whether and how these were avoidable. Then we raise regular reports to SMOH. | <p>Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021</p> |
| <p>MPDSR process: hospital level</p> <ul style="list-style-type: none"> ● The hospital is responsible for investigation of any maternal death ● There is a maternal death committee that meets regularly or when there has been a death ● A focal point is nominated for the investigation and to report the death ● This enables the hospital to understand the main causes of maternal death and to take action by developing plans and procedures to avoid similar deaths in the future. | <p>Interview, Referral Hospital Medical Director, Sudan, 5 June 2021</p> |
| <p>UNFPA provides practical support and training</p> <ul style="list-style-type: none"> ● Workshop held to enable teams from across Arab States Region to learn, share experience and build skills. ● Strategy includes to strengthen national plan for the improvement of the civil registration and vital statistics system. ● Seven strategic areas to support quality improvement included: <ul style="list-style-type: none"> ○ Integration of MDSR into the routine epidemiological surveillance system to make maternal deaths a reportable event just like epidemic diseases ○ Master the major inequities between regions through coaching, training, support, monitoring and evaluation, motivation ○ Invest more in the advocacy and empowerment of decision-makers ○ Integrate MDR into the sectoral strategy as a lever for the quality of care, and human rights ○ The human factor is the key to success: The stability of health providers depends on the continuity of the staff motivation to embark in MDSR process and on the quality of data collected (speed and completeness) ○ Strengthen the leadership of the central unit and the focal point of the region ○ Ensure coordination between all actors outside the health department and between levels of care ○ Monitor recommendations so that the MDSR is action-oriented and improves the quality of care locally | <p>Université Mohammed VI des Sciences de la Santé and UNFPA Arab States Regional Office, Saving Mothers' Lives through advancing Maternal Death Surveillance and Response, Arab States regional MDSR Workshop, Casablanca, 22-23 July 2019. p.69</p> |

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| <ul style="list-style-type: none"> There is a need to “lighten” the collection and monitoring tools (make them easier, more user-friendly) in order to enable health professionals to contribute more systematically to the success of this approach and ensure that recommended actions and interventions have been implemented. | |
| <p>MPDSR reporting culture still lacking</p> <ul style="list-style-type: none"> Focus is needed on the “proper identification and reporting pathway (no shame no blame), efficient quality improvement process, stakeholders’ participation at national and states levels and legal framework addressing mandatory notification and information should not be for litigation.” Improvements to reporting and notification suggested including: <ul style="list-style-type: none"> Short reminder workshop of two days for each state on how to notify and record Strengthen referral system by midwives with strict criteria for hospital delivery and refer for hospital delivery in ample time, using tel. communication before referral Strengthen state supervision for midwives and commitment of SMDR for regular meeting and response to every maternal death Strengthen utilization and adherence to management protocols at all levels to hospitals with strict criteria for monitoring adoption of protocols Design and endorse legal framework for MDSR, to abolish fear of litigation. | <p>UNFPA, Sudan Maternal Death Surveillance and Response Annual Report, UNFPA Khartoum, 2018. p.18</p> |
| Togo | |
| <ul style="list-style-type: none"> In 2018, Burkina Faso, Burundi, Niger and Togo started systematically documenting the case fatality rate from direct obstetric complications in EmONC facilities, gaps in midwives, stock-outs of life-saving commodities, the number of maternal deaths notified and the numbers reviewed. They also focused on mentorship for both pre-service and in-service midwives as well as capacity-building for teachers. | <p>The MHTF UNFPA, Annual Report 2018, Togo, 2019</p> |
| Uganda | |
| <ul style="list-style-type: none"> It was observed that some health facilities fear to report maternal/perinatal deaths as they fear reprimand from district leaders, politicians and/or the police. Sometimes, next of kin are told to take away the deceased without any record of having attended the health facility. Cases of perinatal death are mis-recorded as abortions or as a child death. Some of the approaches used include conducting monthly reviews of maternal deaths by in-charges and DHOs, follow-up phone calls to sites with maternal deaths; reporting via personal mobile phones using WhatsApp; streamlining the review process, etc. Regional efforts to address these gaps included on-site mentorship of CEmONC facility teams, implementation of quality improvement projects aimed at reducing facility delays accessing emergency obstetric care. USAID supported procurement of MNCH equipment such as BP machines, resuscitation equipment, thermometers and delivery kits to USAID/RHITES supported districts. | <p>MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response Report 2017/1, 2019</p> |
| <ul style="list-style-type: none"> But other partners are doing the same (MPDSR) – UNICEF is doing a similar activity in MPDSR but covering the entire district, HC III and VI - is open for all facilities in the district. UNFPA focuses only on 3 sites (i.e. health facilities) – UNICEF covers the other health facilities. UNICEF started supporting MPDSR this year. Before, they were more focused on HIV, but when the DHO | <p>MoH, Gulu District, Uganda, May 2021</p> |

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| <p>raised the issue of high number of maternal deaths, UNICEF listened. “We said to UNICEF, can we please do more on dialogue/sensitisation of the communities on the importance on facility deliveries – using the HIV and TB funding.”</p> <ul style="list-style-type: none"> ● “We need more UNFPA support for MPDRS – they only support 3 facilities (2 in town, 1 in the district) – we need funds for DSA to travel there for the day. If a death occurs at one of these three facilities, we sometimes need to go to the lower facility that referred the patient – but we do not have the funds to do so.” | |
| <ul style="list-style-type: none"> ● “When MoH introduced MPDSR into the system, in the beginning, the way it was brought and being enforced by the MoH, it appeared as if it was a “fault finding intervention.” So somehow, many health workers retracted. You can imagine, at that point, if a mother died, the committee sat down, identified that the doctor who should have done operation, was not available, therefore the recommendation is “doctor should be more available” – report would be sent to MoH, with a monitoring done by the president’s office – they would follow-up on the case and arrest and prosecute the doctor. So, it appeared to be a punitive intervention. When the MoH realised that they started changing the approach. That made it difficult for health facilities to immediately report, because you would be considering, if I report, how safe will I be? HCW did not feel safe of the consequences when they reported. But it is changing, because all of us realise that moving in that direction will not help. ● During that time, reporting was so low, HCWs would keep quiet. So, moving forward, we need to show HCWs that when they report, we support them in removing the challenges, not punishing them. We identify the challenges, for example if the commodity (e.g., misoprostol etc.) was lacking, and that was the reason for the bleeding/death, then we should help solve that problem. If the team reports that there was a challenge in the community, e.g. the first delay contributed to the fresh still birth, when this is brought to our attention, at DHO level, we should support the facilities to go to the community to talk with them. I think if we, DHO, show our facilities/providers that we are there to support them, they will be more comfortable reporting. ● When we have seen an increase in notifications and reviews, it is because we DHO look at it that way – as a supportive intervention, not punitive. In some places, there is an issue, and we need to take disciplinary action – or we place a senior person to support someone with skills lack.” | <p>Interview, MoH staff, Lawmo District, Uganda, May 2021</p> |
| <p>Operations research on management of PPH</p> <ul style="list-style-type: none"> ● UNFPA is supporting operational research in collaboration with WHO on PPH management in West Nile and South Sudan. This is part of an effort by a coalition in East Africa to end maternal deaths due to PPH through the study of heat stable Cabetocin (prevention) and Tranexamic Acid (treatment of women with PPH). (Oxytocin is generally used, but there are challenges with the cold chain.) UNFPA staff are part of the technical meetings; other agencies have also provided TA. These drugs were recently approved by Health Policy Advisor Committee, which is chaired by the Permanent Secretary. “We are glad to have the TA from UNFPA.” | <p>Interview, MoH staff. Kampala, Uganda, May 2021</p> |

Area of Investigation 4: Obstetric fistula and other obstetric morbidities

Evaluation Question 4: To what extent has the MHTF contributed to the capacity of governments to develop, implement and monitor costed and time-bound national strategies for ending fistula cases that are founded on: prevention; access to quality treatment of fistula cases and other obstetric morbidities; and social reintegration of obstetric fistula survivors?

Sub-questions:

- a) To what extent has MHTF/ UNFPA contributed to the government capacity to develop, implement and monitor costed and time-bound national strategies for ending fistula?
- b) To what extent has MHTF/UNFPA contributed to building government capacity at national and sub-national levels equally across prevention, access to quality treatment and social reintegration of survivors?
- c) To what extent has MHTF been an effective platform for the Global Campaign to End Fistula?

Evaluation criteria

Relevance, effectiveness, efficiency

Rationale

Obstetric fistula is caused by prolonged obstructed labour and is an extreme consequence of poor access to basic emergency maternal health care. Once fistula occurs, surgical repair is the only option. Surgical skills needed draw across disciplines (gynaecology, urology, general and plastic surgery, in some cases also gynaecology). Recovery time is protracted and not certain. Post recovery, women and girls may not be able to return home and, in most cases, may need a range of social protection support. Obstetric fistula is thus a complex development problem that has multiple dimensions. MHTF aims to support countries to take steps to prevent and respond to fistula and similar conditions to reduce maternal emergencies, save the lives of newborns, and improve quality and availability of care. Fistula incidence reflects proximity and use of emergency obstetric care (EmONC) and referral capacity making prevention part of a comprehensive maternal health strategy. Post fistula repair depends, to some extent, on identifying sufferers and connecting them with services. Post fistula recovery depends on a multi-sectoral approach to well-being, employment and skills, social reintegration and other factors. As fistula is still poorly understood and sufferers are hidden, data needs to be treated carefully as increasing numbers could be a sign of improved service response rather than increasing incidence. Although it has its own fistula aims, the MHTF also hosts the Global Campaign to End Fistula which works with a mandate from the UN Secretary General & UN member states to end fistula in 55 countries. The campaign is largely merged with the MHTF goals on fistula but reaches beyond the scope of the MHTF and brings its own funds to bear.

Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula

Indicators:

- Development of costed time-bound national and sub-national strategies that set out meaningful prevention, treatment and recovery objectives and strategies.
- Examples of implementation of plans and progress rolling out plans to sub-national and community levels
- Fistula indicators incorporated into the HMIS at national and sub-national levels
- Monitoring arrangements in place for fistula strategies across the three dimensions (prevention, treatment, recovery)
- Examples of policy dialogue and development between national and sub-national health authorities especially around linking to EmONC networks
- Examples of engagement with communities around fistula prevention and management, for example, maternal emergency transportation plans
- Trends in the identification fistula cases

Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula

- **Examples of investments in preventing, treating, and supporting recovery from fistula**
- **Establishment and operation of programmes for staff training to implement strategies (surgery and nursing and community health workers).**
- **Number of fistula repairs undertaken**
- **National and local systems incorporate multisectoral engagement to address fistula, for example with nutrition, social protection, employment, and training sectors.**

| Observations | Sources of evidence |
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| <p>Global</p> <ul style="list-style-type: none"> ● “Ending obstetric fistula is critical to achieving the Sustainable Development Goals and fundamental to improving MNH. Worldwide, an estimated 50,000 to 100,000 women develop fistula annually and approximately 2 million women currently live with fistula, which is a burden in almost 60 countries. Its occurrence is a violation of human rights and a reminder of gross inequities. Although preventable and virtually non-existent in developed countries, fistula continues to afflict many poor women and girls worldwide who lack access to health services. Scaling up national capacity to provide access to comprehensive emergency obstetric care, treat fistula cases and address the underlying health, socioeconomic, cultural and human rights determinants is fundamental to eliminating fistula.” | <p>UN General Assembly, Report of the Secretary General, intensifying efforts to end obstetric fistula within a generation, 31 July 2018, p.2</p> |
| <ul style="list-style-type: none"> ● Under the expanded scope for Phase III, MHTF will “broaden the focus on obstetric morbidities, including obstetric fistula, uterine prolapse, severe anaemia and chronic pelvic inflammatory disease.” (p.15) ● The outcome on fistula (Outcome 4) is: “Quality SRH information and services are accessible to prevent and treat obstetric fistula and other obstetric morbidities. <ul style="list-style-type: none"> ○ Strengthened health systems to prevent obstetric fistula and expand access to quality treatment for obstetric fistula (output 13) ○ Fostered and enhanced national leadership, ownership, and accountability on ending obstetric fistula and other obstetric morbidities (output 14) ○ Strengthened quality of social reintegration/rehabilitation programmes for obstetric fistula survivors (output 15)” (p.24) ● “The main priorities that the MHTF will continue to support include the development of costed, time-bound national strategies and action plans for ending fistula; the creation or strengthening of government-led national task forces to convene all partners and stakeholders to coordinate implementation and monitoring of the national strategy; and advocacy for appropriate resources. The MHTF will also support national capacity-building to ensure that each country has a sufficient number and distribution of EmONC services to prevent fistula from occurring; expert, competent fistula surgeons and care teams to effectively treat fistula when it does occur; and comprehensive, women-centred social reintegration and rehabilitation services. The social reintegration programmes aim to break the cycle of poverty and vulnerability that render women and girls vulnerable to fistula in the first place. Further progress will be made to shift from campaigns to a more sustainable health-service delivery mode with permanent specialized fistula units offering quality care and scaled-up routine treatment capacities. (p. 41) | <p>UNFPA, MHTF Business Plan Phase III (2018-2021), 2018</p> |

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| <p>Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula</p> | |
| <ul style="list-style-type: none"> ● UNFPA has been active in fistula programmes since the launch of the global Campaign to End Fistula in 2003. This platform includes x partners and is now active in more than 55 countries. UNFPA leads the Campaign and has supported more than 113,000 surgical repairs for women and girls, while partner agencies, such as the Fistula Foundation and EngenderHealth (with USAID support), have supported many more. Through the MHTF, UNFPA has also supported the training of thousands of health workers to prevent and treat fistula. In 2013, the UN commemorated the first International Day to End Obstetric Fistula (May 23) to raise awareness and mobilize support around the globe. In 2018, member states adopted a new UN resolution on fistula, calling for an end to fistula within a decade in line with the 2030 SDG agenda. This resolution put fistula on the same level as other major global initiatives such as ending preventable maternal and newborn deaths, ending HIV, ending female genital mutilation and eradicating polio. | <p>UNFPA website: https://www.unfpa.org/obstetric-fistula#summery105936. Updated 23 May 2020</p> |
| <ul style="list-style-type: none"> ● Fistula is a very important area for MHTF; UNFPA is the only organization that focuses on it. Fistula exists because the health system fails women. | <p>Interview, Development partner (bilateral), July 2021</p> |
| <ul style="list-style-type: none"> ● Fistula is a critical element from a human rights perspective and a core component of the MNH agenda. It is linked to the other areas (EmONC, midwifery, MPDSR); UNFPA takes the lead on this for the UN agencies and “we are looking to support their work.” | <p>Interview, UN agency staff, July 2021</p> |
| <ul style="list-style-type: none"> ● This partner earmarks funding for fistula within the MHTF. They support fistula because it can be “easily” eliminated through education, prevention, etc. and because the work is concrete and practical. The programme delivers visible results (number of repairs, number of reintegrated clients, etc.) in countries. UNFPA presence in a large number of countries is a critical factor for this donor’s support of the programme. ● The UNFPA approach to fistula is comprehensive, and covers education, information, midwifery, services and systems. “We assess it positively every year and always recommend that it can be continued. The hope would be to close the programme eventually because of lack of need.” ● UNFPA is responsive and takes an inclusive approach to its donors regarding information shared. | |
| <ul style="list-style-type: none"> ● UNFPA brings a lot to the table for fistula: No one has the reach that UNFPA has, e.g., having a resolution signed by all member states. UN is a unique body – the resolution, the convening power etc. At a country level UNFPA has lots of reach, working in more countries (55) supporting fistula work than any other partners. In terms of funding, it varies from year to year, but UNFPA would be among the top donors of fistula work. ● UNFPA has the integrated package, which includes SRHR work, human rights work. The fistula team has worked very closely with the gender, human rights, and culture branch and this brings a lot to fistula, even beyond the SRH branch, for example with family planning to add to the prevention side. ● MHTF works to ensure sustainability, integrate fistula within government, bringing it to the forefront of government and bringing partners together. UNFPA encourages governments to establish national task forces whose role is to ensure oversight and coordination of funding coming into the country. If UNFPA had not supported these strategies and structures, fistula work would not be as coordinated, as we see in other countries. Integrating fistula into national health programmes can contribute to the mobilisation of funds and strengthen partnerships. | <p>Interview, MHTF staff, New York, February 2021</p> |

| Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula | |
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| <ul style="list-style-type: none"> ● Fistula is our case for quality of care; when fistula increases it means that quality is bad. Midwifery is one of the most important areas for fistula prevention and treatment. ● Many donors are interested in fistula; MHTF can utilize this interest to raise the profile of UNFPA in maternal health so that the other focus areas benefit. ● With fistula, we can attract other donors that do not fund our usual [SRHR] portfolio. MHTF could benefit from resource mobilisation for fistula; for example, addressing fistula is the pitch to sell to donors with technical solutions such as EmONC and MPDSR (note: family planning not mentioned). | Interview, MHTF staff, New York, February 2021 |
| <ul style="list-style-type: none"> ● Work on EmONC and MPDSR is closely linked to fistula; fistula is one indicator for quality of care. | Interview, MHTF staff, New York, February 2021 |
| <ul style="list-style-type: none"> ● MHTF works on four areas in fistula programming: prevention, treatment, reintegration and advocacy. Prevention includes midwifery and EmONC. The fistula fund provides more leeway to support fistula repairs. Within the team, there are different opinions about whether or not UNFPA resources should be used for repair. Some say we should not be doing treatment; others say that UNFPA has a mandate from the UN. There is a desire from UNFPA leadership for the campaign to be visible and for UNFPA to lead it; however, this stance is not shared fully within the MHTF team. ● Even though MHTF funding for fistula declined and “we lost human resources in the regional and headquarters.” ● At the same time resources declined, expectations have increased as other obstetric morbidities are being considered. Morbidities are cross-cutting within MHTF and within the organization. For example, the MHTF team is currently working with the office in Geneva to develop a resolution on maternal morbidities for an upcoming human rights council meeting. Morbidities go beyond fistula and encompass STIs, malaria, EmONC, etc. | Interview, MHTF staff, February 2021 |
| <ul style="list-style-type: none"> ● This agency is developing a five-country project to address fistula; UNFPA is a preferred partner because of its focus and expertise in SRHR, gender. Currently conducting a situation analysis and review in five countries Afghanistan, Gambia Pakistan, Sierra Leone and Somalia. The project focus on fistula will be a comprehensive approach, including an integration of gender. Funding will not go directly to UNFPA but will be directed to national institutions in countries. | Interview with Regional Multilateral Development Agency, Technical specialist, July 2021 |
| <ul style="list-style-type: none"> ● UNFPA plays a key role in global leadership in fistula – mostly agenda-setting and defining the overall framework for what is needed in terms of awareness-raising, community engagement, training, reintegration and support. The work UNFPA has done with the UN Secretary General to put fistula on the global stage has been useful. ● There are a couple of issues that need more attention: <ul style="list-style-type: none"> ○ Lactogenic fistula is a “whole other can of worms.” As a community we need to understand what is the plan and how to address this? ○ We do not have great data on follow-up and the long-term outcomes for women who have had surgery. ○ A major challenge is data collection. Reporting on the number of surgeries alone is not enough. “We do not have confidence in the data coming from UNFPA COs, as they are not defining the different surgical classifications. Some count fistula, some also count uterine prolapse and examination under anaesthesia, meaning we are comparing apples to oranges.” | Interview, International NGO senior manager, September 2021 |

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| <p>Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula</p> | |
| <ul style="list-style-type: none"> • There are a few advocacy and funding organisations for fistula, e.g., Fistula Foundation (private donations), EngenderHealth (USAID), and Freedom from Fistula join UNFPA as supporters of this work. There is lots of concern about future funding for fistula. Resource allocation has been minimal and the cost of delivering care far outstrips the needs. • At global level, UNFPA has been an excellent partner; there is true, positive collaboration with the team at UNFPA HQ. They work hard to champion the work of others in the partnership. However, in countries, there have been instances where UNFPA staff have behaved in a proprietary manner and seemed threatened when group actively worked on fistula. | |
| <ul style="list-style-type: none"> • “In a Commentary in the Lancet Global Health commemorating the 2019 International Day to End Obstetric Fistula, leaders in the field of maternal health/ fistula and safe surgery underscored the critical role of universal access to skilled care at birth – including emergency obstetric, neonatal and newborn care and safe surgery – for ending preventable maternal and newborn mortality and morbidity including obstetric fistula and stillbirths. Drawing upon recommendations from the Lancet Global Health Commission on High Quality Health Systems in the Sustainable Development Goals Era and the Lancet Commission on Global Surgery, the authors emphasized ensuring all women and girls in need receive timely, high quality, life-saving obstetric surgery as a fundamental human rights issue and as a key strategy for achieving the Sustainable Development Goals.” | <p>UN General Assembly, intensifying efforts to end obstetric fistula within a decade, Director General Report, 28 July 2020, p.14</p> |
| <p>Regional</p> | |
| <ul style="list-style-type: none"> • No observations | |
| <p>Benin</p> | |
| <ul style="list-style-type: none"> • Le Bénin s’est engagé dans la campagne globale de prise en charge de la Fistule Obstétricale (FO) depuis 2003. Mais c’est en Janvier 2009 que le Projet intégré de lutte contre la Fistule Obstétricale a pris corps et est soutenu par une stratégie au niveau national. • Une stratégie holistique : UNFPA a soutenu (i) la prévention, (ii) le traitement des cas, (iii) la réintégration psycho-sociale et économique des femmes guéries. • Les hôpitaux de prise en charge régulière des cas de FO sont : Hôpital Saint Jean de Dieu (HSJD) de Tanguiéta, Hôpital Evangélique de Bembèrèkè (HEB), Centre Hospitalier Universitaire Départemental (CHUD) Parakou, Centre National Hospitalier et Universitaire Hubert Koutoukou MAGA (CNHU-HKM), Centre Hospitalier Universitaire –Mère Enfant Lagune (CHU-MEL), Hôpital Sounon Séro (HSS) de Nikki, Hôpital de Zone (HZ) Banikoara, Centre Hospitalier Départemental (CHD) Mono. • Exemple d’investissement sur le dépistage et le traitement : De janvier 2009 au 31 Décembre 2018, l’UNFPA en collaboration avec différents partenaires a contribué à dépister 1501 cas de FO, traiter 1335 cas de FO et guérir 1069 cas. Le taux de succès est de 80,53% pour les fistules traitées. • Evaluation des coûts de réparation en 2018, qui a motivé le changement de stratégie : Afin de contribuer à la prise de décision concernant les subventions qui sont offertes aux structures concernées, en collaboration avec le Ministère de la Santé, l’UNFPA a organisé du 22 au 28 juillet 2018, une mission de collecte de données relatives aux coûts des prestations de réparations des FO dans les hôpitaux de prise en charge sur toute l’étendue du territoire national. L’objectif est d’évaluer le coût moyen de la prise en charge chirurgicale des FO dans les formations sanitaires au Bénin | <p>UNFPA Benin, Article Lutte contre la fistule obstétricale, pas de date</p> |

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| <ul style="list-style-type: none"> ● Si je considère les Fistules et SDRM, je peux dire que le programme précédent a joué un rôle vraiment d'avant-garde. Cela a créé une prise de conscience plus aigüe de la chose et d'autres sont venus. | Entretien, Agence multilatérale, Juillet 2021, Benin |
| <ul style="list-style-type: none"> ● Au niveau des fistules, il n'y a pas beaucoup de partenaires et UNFPA a bien travaillé dans ce domaine. On a tous vu leur implication dans la formation des médecins, la prise en charge des interventions chirurgicales et la prise en charge des femmes après chirurgie. C'était vraiment bien. Mais j'ai appris qu'actuellement UNFPA s'est désengagé et c'est la fondation de la première Dame qui appui ça maintenant. | Entretien, Agence bilatérale, Juillet 2021, Benin |
| <p>Le produit 2 du Programme MHTF en 2018 pays était : La capacité nationale de prévenir et de gérer la fistule obstétricale et de promouvoir la réinsertion sociale des patientes est améliorée.</p> <p>Résultats :</p> <ul style="list-style-type: none"> ● Quatre centres de prise en charge de Fistules Obstétricales (FO) sur huit ont intégré leurs rapports dans DHI ● 137 cas de FO sont dépistés dont 132 réparés ; ● L'évaluation des résultats de la réparation des FO trois mois après l'intervention a été réalisée ; ● 60 femmes réparées et guéries de FO sont réintégrées dans leur communauté ; ● L'évaluation des résultats de la réintégration sociale des femmes réparées a été réalisée. | UNFPA Rapport MHTF Benin, 2018 |
| <ul style="list-style-type: none"> ● Deux ateliers annulés (actualisation de la stratégie nationale pour l'élimination des FO et l'atelier pour créer un consensus national sur la prévalence et l'incidence des fistules obstétricales) ● Intégration dans le SNIGS et le sous système de santé familiale à la DSME, les données relatives aux FO dans les centres de prise en charge (site web) – activité réalisée ● Suivi trimestriel de 100 femmes opérées de FO jusqu'à un an et riposte et suivi annuel de la réintégration sociale de 80 femmes guéries de FO et riposte: activité réalisée (révélant que 152 patientes ont été opérées; 116 ont été déclarées guéries et 58 femmes guéries réintégrées, soit un taux de réintégration socio-économique de 50,0%. | UNFPA Rapport MHTF Benin, 2019 |
| <ul style="list-style-type: none"> ● La seule activité rapportée en 2020 : Documenter sur la base d'une recherche action l'intégration de la chirurgie réparatrice et réinsertion sociale de 30 femmes survivantes de FO avec la fondation de la Première Dame; mention de la Fondation Claudine Talon et l'ONG Essor comme principaux acteurs ayant effectué 115 réparations dans l'année | UNFPA Rapport MHTF Benin, 2020 |
| <ul style="list-style-type: none"> ● Recueil d'évidences: In 2018, the MoH of Benin, avec technical and financial support from UNFPA and the MHTF, released the findings of an evaluation of the follow-up to surgical fistula repairs three months after discharge. The report identified the epidemiological profile of women avec obstetric fistula and the success rate of their surgical repairs, and provided recommendations for improving the management of fistula cases. ● The availability of quality fistula data contributes to evidence-based development and advocacy to end the condition. By 2018, 16 MHTF-supported countries (including Benin) had integrated fistula-related indicators into the national health management information system, indicating a move towards more standardized reporting of diagnosed and treated obstetric fistula cases and the tracking of fistula data from facility levels to the national level. ● Social reintegration for survivors, however, continues to lag behind, avec services offered to only a fraction of patients. Follow-up is still a major gap in the continuum of care. In 2018, 2,177 women and girls in MHTF-supported countries received varied forms of social reintegration, including microfinance (Benin and Côte d'Ivoire); | UNFPA, MTHF Annual Report, 2018, 2019 |

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| <ul style="list-style-type: none"> • Avant, on finançait la prise en charge nos seulement à travers la formation des prestataires mais aussi le soutien aux frais de prises en charge et à la réinsertion • Maintenant, on se concentre sur la prévention : Les interventions en PF intègrent la prévention de la fistule, mais nous n'allouons plus de ressources à la réinsertion sociale (mais on a des partenariats avec d'autres PTF) ; des ressources sont aussi allouées au renforcement des capacités des prestataires de service et à la formation des gynécologues et spécialistes (mais on ne paie plus la réparation) • L'avantage comparatif du MHTF est le renforcement de capacités car les prestataires contribuent à renforcer les systèmes de santé – cela assure la pérennité • Certains staffs regrettent ce désengagement : UNFPA a toujours été vu comme le leader en matière de fistule mais pour des raisons financières, le Siège a demandé que l'on arrête de travailler sur les réparations car d'autres le faisaient... mais je pense que UNFPA pourrait quand-même financer les réparations pour accroître l'accès... D'autres nous ravissent nos belles interventions ; quand je vois le travail fait au niveau national sur la fistule aujourd'hui, il faut se battre pour montrer que UNFPA était le précurseur. La Fondation Claudine Talon finance la réparation et la réintégration maintenant, et gère le Centre de santé de Taurou, que UNFPA avait contribué à mettre en place pour l'autonomisation des jeunes-filles en 2009. Mais les traces de UNFPA dans le centre ont disparu et les autres prennent nos idées. | <p>Entretien UNFPA bureau de pays, juin 2021, Benin</p> |
| <ul style="list-style-type: none"> • C'est un sujet critique – il y a eu des erreurs qui ont créé tensions et des errements [lors du changement de stratégie] | <p>Entretien UNFPA bureau pays, Mai 2021, Benin</p> |
| <p>Sudan</p> | |
| <p>Interest in and commitment to developing a fistula Strategy "...More focus and strategic interventions to speed the ending fistula campaign in the country that started years ago..."</p> <ul style="list-style-type: none"> • The weak health system in general and the presence of other competitive priorities challenged the health sector and UNFPA to mobilize adequate resources to ensure the sustainability of the programme and services. • According to the 2018 national EmONC assessment, 15 per cent of health facilities in Sudan can provide surgical repair to Obstetric Fistula survivors, but the indicators to measure the quality of the services are still a missed point. | <p>UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan. p.3</p> |
| <p>Sudan Fistula Strategy 2019</p> <ul style="list-style-type: none"> • By the end of 2019, 69 per cent of MHTF-supported countries had developed national strategies to end fistula. Four more countries, Liberia, Malawi, Rwanda, and Sudan, began developing national fistula strategies. | <p>UNFPA, MHTF 2019 Annual Report, Sudan. Khartoum, 2020</p> |
| <p>Fistula Strategy</p> <ul style="list-style-type: none"> • UNFPA also supported the technical review of the National Fistula strategy once it was completed. • The core document and the operational plan were finalized; the costing exercise is ongoing. • The Strategy was intended to be endorsed by the FMOH before the end of December 2020 according to this report. • The Strategy has still not been endorsed as of July 2021. | <p>UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan</p> |
| <ul style="list-style-type: none"> • Fistula is "moving in the right direction". As of 2021, UNFPA is working with FMOH on a fistula plan and costing to guide the country on ending fistula in Sudan. The strategic plan is currently under review and UNFPA is awaiting endorsement of the new plan, which is ready, but the FMOH needs to approve it. | <p>Interview, RH Team, UNFPA CO Khartoum, 17 June 2021</p> |

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| Expanding the fistula response beyond repair | UNFPA, MHTF 2019 Annual Report, Sudan. Khartoum, 2020 |
| <ul style="list-style-type: none"> Through MHTF support, Sudan developed an evidence-based social reintegration programme that informed its national fistula strategy. | |
| Ongoing strategy and policy process | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |
| <ul style="list-style-type: none"> This activity includes the development of fistula strategy, National Fistula Task Force, identification of fistula treatment sites (central and state levels) and investments needed in fistula treatment sites in six states (Kassala, Blue Nile, North Darfur, South Darfur, West Darfur and Central Darfur). The strategy draft is now being reviewed in the FMOH and CO staff are “nudging” but at the same time are aware that the FMOH is diverted by other challenges. | |
| <ul style="list-style-type: none"> UNFPA support to Fistula programme included support to national strategy development, in addition to most of the task force meetings and capacity building programmes. There is still a lot of work to do including dissemination of the strategy, strengthening of the reporting system. All proposed work is well coordinated with UNFPA. Practical challenges include human resources capacity for prevention, diagnosis and repair but now expanding to develop a comprehensive approach to reintegration. This element of fistula is multisectoral. | FMOH, Interview with National Fistula Coordinator, Khartoum, Sudan, 1 June 2021 |
| Investments and practical focus at sub-national level | Interview, SMOH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| <ul style="list-style-type: none"> UNFPA supports the development of the national strategy and capacity building programmes, notification and referral of cases and also surgeries, medical treatments and costs for patients during hospital admission. | |
| <ul style="list-style-type: none"> Fistula services are expanded with practical support, investment in prevention measures, diagnosis and notification, management of patients and support to patient referral. | UNFPA Group Meeting, 5 June 2021, Khartoum |
| Uganda | |
| National Fistula Strategy | UNFPA Uganda, 2018 MHTF Annual Report, 2018 |
| <ul style="list-style-type: none"> UNFPA and USAID fistula care plus project through the national Fistula Technical Working Group is supporting the review and costing of the fistula strategy to align to the national and international policies and strategy documents including the Health Sector Development Plan, the Vision 2040 and the SDGs. There is continued awareness creation and visibility of Fistula at national, district and community levels including fistula walks and commemoration of the National fistula day. There is a downward trend in reduction of the estimates of the prevalence of fistula as indicated in the UDHS surveys. This has been possible through support from UNFPA and key Global and National partners including USAID/Fistula Foundation, AMREF, Terrowode, World Vision, Women at Work International (WAWI), Medical Teams International (MTI) and Uganda Village Project have been fundamental in this Campaign and progress towards eliminating fistula in the country. | |
| <ul style="list-style-type: none"> “The Obstetric Fistula strategy 2020/21-2024/25 was revised and approved. The strategy aligns to the national and international policies and strategy documents including the Health Sector Development Plan-II, the third National Development Plan (NDP III), the Vision 2040 and the SDGs. The strategy’s mainly focuses on strengthening the integration of fistula repair as a routine service and practice at the National, Regional and selected General hospitals across the country shifting from the camp-based mode of repair and treatment.” | UNFPA Uganda, Final Annual Report for MHTF, 2020, p.3 |

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| <ul style="list-style-type: none"> ● “MHTF was captain in the area of fistula – because they supported the national fistula strategy -- the revision. The new strategy gives more focus on shift from camp-based repairs to more facility based routine repairs. Of course, that is quite a big dream. We have reviewed our HR structure to allow for specialists (obstetricians, paediatricians and others) at general hospitals. So now that we have specialists and the general hospitals, we can start building their capacity in fistula repairs – because it is very specialized. Obstetricians etc. cannot do fistula repairs without extra training and skills development.” ● UNFPA (MHTF) funded the fistula strategy revision. The development of the revised strategy included technical inputs from WHO, UNICEF, USAID, AMREF and Medical Teams International (MTI). USAID used to be the main donor for fistula through EngenderHealth, especially for camps and outreach; however, this shifted in 2018 with EngenderHealth phasing out its support. UNFPA has scaled up to ensure that there are more partners, such as AMREF and MTI. | <p>Interview, MoH Uganda, May 2021</p> |
| <p>UNFPA leadership and Fistula TWG</p> <ul style="list-style-type: none"> ● UNFPA is considered the main partner for MoH on fistula and has provided leadership on policy development: “For the one (i.e. fistula strategy) that just came out, UNFPA has provided leadership to the MoH, and of course also with the TWG. UNFPA has also organised annual fistula days in Uganda, by bringing together the TWG, and by funding part of the activities. Other partners also support us, but UNFPA has provided leadership in that.” | <p>Interview, NGO partner, Uganda, May 2021</p> |
| <ul style="list-style-type: none"> ● UNFPA provided support to enhance the function and operations of the National Fistula Technical Working Group (TWG), which held 3 quarterly coordination meetings, a virtual commemoration for the International Day to End Obstetric Fistula and sensitization and mobilization campaigns for fistula. UNFPA supported the Fistula TWG to develop and approval a set of National Fistula management HMIS documentation and reporting tools, such as: <ul style="list-style-type: none"> ○ OB/Gyn and fistula theatre register ○ Fistula care register ○ Treatment and follow-up register ○ Registration form for documenting clinical notes and monitoring of care ● “To improve data quality, working with AMREF, UNFPA supported printing of Fistula Registers data quality assessment and Validation in at least seven selected districts to improve the quality of data. Data reviews of Repairs have also been incorporated into the Regular reviews to monitor implementation of the Strategy. (p.8) | <p>UNFPA Uganda, Final Annual Report for MHTF, 2020</p> |
| <ul style="list-style-type: none"> ● UNFPA supports the technical working group on fistula. “Fistula is sometimes “orphaned” by the number of partners/donors supporting – when a donor leaves, it leaves a gap.” But at least the MHTF has been able to support the TWG that has been a platform for resource mobilization, but also working together to standardize work, and see what the other partners are doing across the country. ● “Through the TWG, at least we are able to map out who is doing what across the country – in terms of fistula – and the MoH. But also, it is a platform where the MoH sometimes expresses the needs that are there and need to be covered, and through that, it has been able to show gaps, through that, get different partners to come and step in.” It is also a platform to enable the MoH to express their needs. This was especially important in 2020 to ensure that fistula repair services continued during COVID-19 through the provision of PPE and commodities. | <p>Interview, UNFPA Uganda staff, May 2021</p> |

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| <ul style="list-style-type: none"> ● Shifting from camp based to routine-based fistula care and treatment is challenging as it requires continuous training/capacity building of health care providers to be able to perform fistula repairs, as well as significant investments in infrastructure, equipment and infrastructure. | |
| <ul style="list-style-type: none"> ● The overall goal of the FTWG is to ensure harmonized acceleration of prevention, treatment and social re-integration services for fistula under the overall framework of the National Obstetric Fistula Strategy; and leadership of the MoH. It will be led by the clinical department at MoH, which serves as secretariat of the FTWG. The FTWG will meet not less than once every three months ● FTWG outputs include (but are not limited to): Policy proposals (including strategies, guidelines, standards, etc.) for quality delivery of fistula interventions, in line with the National Obstetric Fistula Strategy, Roadmap for Accelerated Reduction of Maternal and Neonatal Mortality & Morbidity in Uganda, and Adolescent Health Policy; Fistula components for relevant sector policy and strategic documents, plans and programmes in particular the HSSIP; MoH Annual Work Plans and Budget Framework Papers; improved coordination of state & non-state actors aligned with National Obstetric Fistula Strategy; increased mobilization and leveraging of resources for fistula interventions; increased coverage of fistula care services; harmonized criteria for training teams, calculating costs, etc.; quarterly fistula partnership forum meetings; harmonized recommendations relevant for prevention, care, treatment, and reintegration; and identification and utilization of best practices. | <p>MoH Uganda, Terms of Reference for the Fistula Technical Working Group, Undated</p> |
| <p>Reported progress in 2019:</p> <ul style="list-style-type: none"> ● Fistula coordination ● Conducted quarterly Fistula Technical Working Group meetings in Q3 and Q4. ● Conducted supportive supervision visits to repair camp sites in Q4 ● Commemorated the IDOF and Fistula Walks in Q2 to raise awareness ● Strengthened national capacity for obstetric fistula management: Q4 - 11 hospitals (Mulago, Arua, Lacor, Hoima, Soroti, Mubende, Mbale, Mbarara, Kisiizi, Kitovu and Terrewode) conducted repair camps (total: 339 cases). No activities held in prior quarters. | <p>UNFPA Uganda, GoU/UNFPA Country Program Support to MoH 2019 Annual Workplan, 2019</p> |
| <p>Reported progress in 2018:</p> <ul style="list-style-type: none"> ● UNFPA supported fistula coordination, including four quarterly TWG meetings and one ad hoc review of the Fistula strategy, chaired by the Commissioner Clinical Services. Draft Validated Fistula Strategy (2019-2024) was presented to Fistula technical working group and forwarded to the Senior management for approval in 2019. | <p>UNFPA Uganda, UNFPA-MoH Annual Workplan Progress Report, 2018</p> |
| <p>Zambia</p> | |
| <p>Fistula “roadmap” and operational plan to end fistula:</p> <ul style="list-style-type: none"> ● Through the roadmap, new resources have been invested to recruit and train surgeons, midwives, SMAGs, and other health workers to identify, mobilize and carry out fistula repairs. ● The Fistula Foundation has joined the campaign to end fistula together with the MoH and UNFPA to identify, mobilize and support treatment for patients with fistula. | <p>Kasunda, G. Obstetric Fistula in Zambia. Undated.</p> |

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| <ul style="list-style-type: none"> ● Through UNFPA technical and financial support, the Draft Operational Plan to End Obstetric Fistula was developed. The plan provides strategic focus on fistula management (prevention, identification, repair, and re-integration) and institutionalization. | <p>UNFPA, Zambia. 2019 Annual Report. 2020</p> | | | | | | | | | | | | |
|--|--|----------------------------|----------------------|-------|-------------------------------------|------------------------|--------|----------------------------|----------------------------|----------|------------------------|-------------------------|--|
| <ul style="list-style-type: none"> ● Over the last decade fistula has received increased attention in national and international agenda. New resources have been invested to improve medical care, train surgeons and health workers and fund units to carry out fistula repair. Education campaigns have alerted more women, families, and communities to the importance of medical care during pregnancy and childbirth as well as the specialized surgery available to help them. ● MoH with support from United Nations Population Fund (UNFPA) held a three (3) days meeting to finalise the fistula operational plan for the country. The main objective was to finalise the fistula operational plan to guide the implementation of fistula activities in Zambia. ● UNFPA supported the MoH to conduct a three-day meeting to finalize the fistula operational plan for the country, the objective of which is to guide the implementation of fistula activities in Zambia. The meeting drew participants from health facilities where fistula repairs are currently being done in facilities and camps. ● The plan is based on a blended model that integrates the UNFPA and EngenderHealth models (summarized in the table below and is aligned with the WHO three-pronged approach. It was resolved that the model would be called, The “Zambia End Fistula Model.” <table border="1" data-bbox="398 790 1550 933"> <thead> <tr> <th>Area</th> <th>UNFPA Model</th> <th>EngenderHealth Model</th> </tr> </thead> <tbody> <tr> <td>Focus</td> <td>Identify, treatment and integration</td> <td>Outlines level of care</td> </tr> <tr> <td>Target</td> <td>Excludes multiparous women</td> <td>Includes multiparous women</td> </tr> <tr> <td>Approach</td> <td>Includes other sectors</td> <td>Inclined to MoH systems</td> </tr> </tbody> </table> | Area | UNFPA Model | EngenderHealth Model | Focus | Identify, treatment and integration | Outlines level of care | Target | Excludes multiparous women | Includes multiparous women | Approach | Includes other sectors | Inclined to MoH systems | <p>MoH, Zambia. Activity/Trip Report: Finalization of the Fistula Operational Plan Report. 2019</p> |
| Area | UNFPA Model | EngenderHealth Model | | | | | | | | | | | |
| Focus | Identify, treatment and integration | Outlines level of care | | | | | | | | | | | |
| Target | Excludes multiparous women | Includes multiparous women | | | | | | | | | | | |
| Approach | Includes other sectors | Inclined to MoH systems | | | | | | | | | | | |
| <p>High-level advocacy via international conference attendance</p> <ul style="list-style-type: none"> ● UNFPA and the Fistula Foundation sponsored a Zambian delegation to attend the 7th International Conference of Obstetric Fistula Surgeons in Nepal in 2018. This conference supported the UN call to end Fistula within a generation and provided an opportunity for the global community dedicated to fistula prevention and care to share experiences and best practices in scientific oral and poster presentations and workshops. ● Conference recommendations on the way forward included: <ul style="list-style-type: none"> ○ Continued efforts by national governments and development partners to work together to improve the availability, accessibility and quality of maternal health services. ○ Efforts to address the growing numbers of iatrogenic fistula through high quality training for surgeons and medical officers. ○ Promotion for the rational use of C-sections and access to those women who need it in a timely manner. ● Global, regional, national and local level strategies and action plans with clear milestones to ensure prevention and care of fistula. | <p>UNFPA Zambia. Mission Report: International Conference of the Society of Obstetric Fistula Surgeons (ISOFS), Nepal. 2018</p> | | | | | | | | | | | | |
| <p>MoH perspectives on fistula</p> | <p>Interview, MoH national staff. Lusaka, Zambia. August 2021</p> | | | | | | | | | | | | |

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| <p>Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula</p> <ul style="list-style-type: none"> ● Fistula is an area that UNFPA has played a role for some time, until the Fistula Foundation joined in. It was approached from a public health point of view alone. “We’ve done fistula treatment without mainly paying a lot of attention to community and health worker engagement regarding the prevention of fistula.” It might look that you are mopping but you have an open tap. If we could have close linkages between activities we have been undertaking on repair with prevention, we will be winning both ways.” ● Efforts to treat are needed, and with increased support and collaboration with UNFPA and Fistula Foundation, there has been more routine fistula service delivery. Fistula should not occur if there is good communication with providers and communities. There is a need to increase the number of people and sites for repair and marry this with prevention strategies. ● Re changes in fistula landscape, there has been discussion that is we are having from people speaking about fistula (iatrogenic vs obstructed labour). More research is needed. The question should be food for thought and moving forward, there is a need for more information. “The C-section rate was very low in this country and now coverage has gone up, but quality has not kept pace. Lots of poor techniques for C-sections. For us, to answer that question with confidence, it needs data.” | |
| <ul style="list-style-type: none"> ● Only UNFPA and Fistula Foundation are supporting Fistula programmes at the moment. Prior to engagement of the Fistula Foundation came in, “UNFPA supported sensitization and they made a very big impact because they highlighted a lot of issues concerning Fistula. UNFPA also has a different way of how they finance the Ministry as they channel those resources to the Ministry through the Ministry of Finance. UNFPA actively participates in the planning that the Ministry makes. I think that is unique.” ● The strategic plan is not yet completed. Fistula Foundation and UNFPA played a big role, particularly UNFPA because they initiated and supported the start of the strategic plan. “We had meetings with them, they made contributions on the document itself and also brought a number of key players together through their support to have this programme done.” Later on, Fistula Foundation joined the effort, and they supported the consultant who was to collect the information and put the documents together. ● In terms of high-level leadership, the Permanent Secretary has keen interest in fistula. “When we have Safe Motherhood Week, UNFPA usually supports the treatment within that week for fistula care. And they also support the Permanent Secretary, including for the first lady to actually attend and grace the occasion.” | <p>Interview, MoH service provider. Lusaka, Zambia. August 2021.</p> |
| <p>Future items for fistula agenda</p> <ul style="list-style-type: none"> ● On the top of the agenda is Iatrogenic Fistula. There is no data on iatrogenic fistula; info is anecdotal. “Going forward, there is a need to establish that health workers are on the lookout for this problem happening.” ● There is a department created with the Department of Clinical Care which includes a cadre national coordinator – one is on Ob/Gyn to coordinate with specialists (senior residents) in provinces to ensure skills are polished through mentorship. “My hope that this team of experts is supported with travel to carry out the mentorship. Training of specialists – MHTF may not put resources to train specialists, but resources have been used to influence the policy direction.” | <p>Interview, UNFPA Zambia national staff. August 2021.</p> |
| <ul style="list-style-type: none"> ● Opportunity also exists for the prevention of fistula because health care staff that are trained in EmONC can contribute to preventing fistula. These health care personnel can prevent delay that may lead to fistula. It is also important for the | <p>Interview, MoH service provider. Lusaka, Zambia. August 2021.</p> |

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| Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula | |
| <p>leadership to become actively involved because the problem of fistula is not isolated; it is occurring within the health care system which has its own leadership at different levels.</p> <ul style="list-style-type: none"> ● “We need more surgeons to treat fistula and more midwives in the rural areas who can manage maternal health more effectively by preventing obstructed labor that leads to fistula and thereby prevent fistula. If we had to have a robust programme, I would advocate for a more robust programme for the prevention of fistula just as much as we treat fistula that has not been prevented.” | |
| <ul style="list-style-type: none"> ● See Assumption 4.3 for inputs related to International Day to End Obstetric Fistula activities (to increase awareness and commitment to fistula at national and sub-national levels) | |
| Bangladesh | |
| <ul style="list-style-type: none"> ● Through MHTF support, Bangladesh and Ethiopia made strides towards integrating fistula into disease surveillance and emergency public health management information systems, respectively. UNFPA supported Bangladesh in conducting workshops to extend and strengthen its online, mobile phone based SRHR surveillance system to include a fistula reporting mechanism. This will be managed by the Institute of Epidemiology, Disease Control and Research of the MoHFW, supported by UNFPA. | The MHTF UNFPA, Annual Report 2019, 2020, p.33 |
| <ul style="list-style-type: none"> ● In 2019, 14 (44 per cent) MHTF-supported countries, Bangladesh, Burkina Faso, Chad, Côte d’Ivoire, the Democratic Republic of the Congo, Ghana, Guinea, Kenya, Niger, Nigeria, Rwanda, Senegal, Togo and Uganda, had integrated fistula-related indicators into the national health management information system. | The MHTF UNFPA, Annual Report 2019, 2020, p.33 |
| <ul style="list-style-type: none"> ● The MHTF continued to address the issue of mental health support and social stigma accompanying obstetric fistula. With its support and in partnership with government ministries and Campaign to End Fistula partners, 1,906 women and girls from nine countries (Bangladesh, Côte d’Ivoire, the Democratic Republic of the Congo, Mauritania, Niger, Nigeria, Sierra Leone, Togo and Uganda) benefited from various social reintegration programmes. | The MHTF UNFPA, Annual Report 2019, 2020, p.35 |
| <ul style="list-style-type: none"> ● In addition, during this time MHTF was also used to work in MPDSR and in fistula prevention programme. In the latter case, UNFPA organized training of trainers for fistula management, prepared a pocketbook on fistula and encouraged district level managers in high prevalence districts to focus on fistula elimination measures. | Interview, MoH Nursing and Midwifery staff, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● The fistula programme started with MHTF funds but is a bigger programme now and is being implemented following a national strategy for fistula which consists of fistula case identification, referral for repair, rehab of patients and reintegration. This involves beyond the Health Ministry, Ministry of Women and Children’s Affairs, Local Government Ministry, Social Welfare Ministry etc. ● This is a great example of ‘catalytic’ effect of MHTF. The current role of UNFPA is to provide technical support to DGHS to eliminate fistula. The fistula elimination programme works through a divisional approach in three divisions- Rangpur, Rajshahi and Sylhet. This support consists of funding training for fistula identification, facilitating referral by supporting transportation and surgery costs for disadvantaged group members, developing capacity of surgeons by facilitating their training, supporting income generation training for rehab of fistula victims. | Interview, UNFPA, Dhaka, Bangladesh, June 2021 |

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| Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula | |
| <ul style="list-style-type: none"> UNFPA has also supported the Obstetrical and Gynaecological Society of Bangladesh in setting up a fistula training institute. There is limited interest among other development partners in this area; UNFPA is therefore advocating with the government for earmarking costs for the fistula programme in an operational plan of the sector plan of government. | |
| <ul style="list-style-type: none"> Fistula: UNFPA had a more active role before. They took the leadership to develop the national fistula strategy. They also developed “master trainers” in fistula and established a centre of excellence in Dhaka Medical College Hospital. | Interview, Other UN Agency National staff, Dhaka, Bangladesh, June 2021 |
| Togo | |
| <ul style="list-style-type: none"> La prise en charge des cas de fistule obstétricale (FO) a été effective en 2020 avec la réparation en routine de 25 cas simple sur 40 prévu pour 2020. 18 nouveaux cas de FO ont été recensés en 2020. Toutefois, l’ampleur de la FO n’est pas bien connue, mais on estime à 1 à 2 cas pour 1000 naissances vivantes dans la sous-région. Cette estimation appliquée au Togo donnerait entre 150 et 300 nouveaux cas par an. - La base de données des fistules obstétricales au Togo est paramétré dans le DHIS2 et les données en cours de collecte. L’utilisation de cette base sera effective en 2021 | UNFPA, MHTF Request Proposal 2019-2022, 2019 |
| <ul style="list-style-type: none"> UNFPA est dans le plaidoyer et prend le lead pour certaines interventions (SONU, Pratique Sage-Femme, SDMR, FO) dans le pays à travers le financement par les fonds MHTF, MUSKOKA Lutte est confrontée actuellement à une disponible de données, une base pour leur gestion vient d’être mise en place Pas de financement local de la stratégie qui repose sur UNFPA, et apports marginaux de CBM et OOAS FO Enquêtes de base conduites par UNFPA, introduction de la FO dans la LOI SR en 2007, Création de la Coalition ONG en lutte contre la FO et leur capacitation pour diagnostic des cas et recensement financement des premières campagnes de réparation et autres activités liées à la FO avant la participation de OOAS, CBM à la suite, finance et anime le fonctionnement du Comité de lutte, sensibilisation des média sur la FO, les plans stratégiques de lutte FO sont élaborés par UNFPA et ont subi des revues déjà avec UNFPA | Interview, UNFPA Togo staff, June 2021 |
| Les rôles spécifiques de l’UNFPA et sa contribution particulière dans le domaine des fistules | |
| <ul style="list-style-type: none"> L’efficacité de l’UNFPA dans la coordination des efforts • Coordination des efforts à travers la Plateforme des partenaires SMI/PF et le Comité national FO Le leadership de UNFPA dans la plateforme Campagne pour l’éradication des Fistules Coordination des efforts à travers la Plateforme des partenaires SMI/PF et le Comité national FO | Interview, UNFPA Togo staff, June 2021 |
| <ul style="list-style-type: none"> “Pour prévenir la fistule, ce que nous faisons, premièrement c’est la ventouse. Nous avons reçu cette formation. Nous appliquons la ventouse à la femme lorsque nous nous rendons compte que la phase d’expulsion est trop longue. Nous faisons la ventouse pour un accouchement et c’est un peu plus rapide. Il y a aussi la référence à temps que nous faisons. Lorsqu’ on fait le travail et vous vous rendez compte que votre capacité est déjà dépassée. Il faut référer la personne. Donc c’est la référence à temps qui va prévenir ces cas de fistule. Il y a une fois, une femme est venue pour justement ce cas. Mais elle vient d’une contrée lointaine. Elle n’est pas de la ville de Tsévié bon. C’est une mauvaise orientation, ce n’était pas ici qu’elle devrait venir mais plutôt au CHR. Après consultation, nous avons remarqué quand même qu’il avait vraiment une fistule et nous l’avions envoyé au CHR (Utilisation de la ventouse, la référence à temps).” | Interview, government service provider (midwife), Togo, June 2021 |

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| <ul style="list-style-type: none"> ● Au plan de lutte contre la fistule obstétricale, pour laquelle plus d'un millier de cas attendent encore leur réparation, le minimum à envisager sur le programme MHTF est la mise place d'une base de données pour non seulement disposer d'un vivier qui va alimenter la réparation des cas et leur suivi, mais aussi pour établir régulièrement les progrès dans cette lutte. | <p>UNFPA, MHTF Request Proposal 2019-2022, 2019</p> |
| <p>Les rôles spécifiques de UNFPA et sa contribution particulière dans le domaine des fistules :</p> <ul style="list-style-type: none"> ○ L'efficacité de UNFPA dans la coordination des efforts ○ Le leadership de UNFPA dans la plateforme Campagne pour l'éradication des Fistules ● L'UNFPA soutien en grande partie, la prise en charge des FO au niveau nationale. Formations de courte durée de deux chirurgiens (un urologue et un gynéco-obstétricien pour la prise en charge des cas simples '2016) Recensement des femmes porteuses de fistules. Ce Suivies au cours de l'année suivantes (n+1) Financement des campagnes de prise en charge organisées au plan national (deux campagnes par an) En 2019, une campagne de prise en charge à l'hôpital St Jean de Dieu d'Afagnan financé par L'UNFPA et la direction du genre sur les fonds de la CEDEAO. Depuis 2020, il a été retenu avec l'UNFPA de passer de façon progressive à la routine. Les fonds ont permis de financer la prise en charge des femmes en routine (20 femmes ont été prises en charge). 2021 : Activité de prise en charge des femmes en routine en cours. ● Fistules obstétricales L'UNFPA soutien en grande partie, la prise en charge des FO au niveau nationale. En 2016, il a eu à accompagner la formation de courte durée de deux chirurgiens (un urologue et un gynéco-obstétricien pour la prise en charge des cas simples. Il a eu également à financer pratiquement toutes les campagnes de prise en charge organisées au plan national. Sur la période 2018 à maintenant, c'est la prise en charge des campagnes. Il est organisé deux campagnes par an. En 2019, une campagne a été co-organisée avec les expatriés qui viennent opérer à l'hôpital St Jean de Dieu d'Afagnan. ● L'UNFPA a également financé une partie de ces ressources en collaboration avec la direction du genre sur les fonds de la CEDEAO. Depuis 2020, il a été retenu avec l'UNFPA de passer de façon progressive à la routine. Les fonds ont permis de financer la prise en charge des femmes en routine. 20 femmes ont été prises en charge. Cette année encore, cette activité de prise en charge est en préparation. Au-delà des aspects de prise en charge, il y a le recensement des femmes porteuses de fistules. Celles qui ont été opérées antérieurement sont suivies au cours de l'année suivantes. | <p>Interview, MoH Togo staff, June 2021</p> |
| <ul style="list-style-type: none"> ● En matière de fistule obstétricale, nous n'avons pas aussi trop de problème parce que il y a certains ONGs qui s'en chargent. Ce sont eux qui vont dans les villages pour récupérer ces femmes. Ce que nous nous avons fait, c'est qu'on a briffé nos prestataires ONG et lorsqu'ils ont les cas comme ça, ils nous informent et nous prenons attache avec l'ONG et on suit le reste au CHR. C'est au CHR qu'il y a des gynécologues qui posent vraiment le vrai diagnostic de fistule pour savoir ce qui va s'en suivre. | <p>District Health Officer, Government, June 2021, Togo</p> |
| <ul style="list-style-type: none"> ● Mettre en place une base de données sur les fistules (Recenser les cas de fistules, mise en place de la base) : Partially achieved ● Pour la fistule obstétricale 1- Le renforcement des compétences des chirurgiens au niveau des régions est nécessaire pour la prise en charge des cas de FO en routine. 2- Le nombre élevé de cas réparés s'est fait grâce à la mobilisation d'autres et partenaires de lutte contre la fistule obstétricale suite au plaidoyer de l'UNFPA. ● Fistula: | <p>UNFPA Togo, MHTF reporting template, 2019</p> |

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| <ul style="list-style-type: none"> ○ Les patientes opérées en 2018 ont été suivies, montrant un taux de guérison de 57 % et le recensement de nouveaux cas fait ○ 15 femmes ont été traitées pour fistule obstétricale contre ○ 25 femmes guéries de la FO ont bénéficié de la réinsertion socioéconomique, 44 autres appuyées en AGR ○ La Journée internationale de lutte contre les FO (JIFO) a été célébrée pour la première fois au Togo ○ La base de données sur les fistules au Togo, à travers le paramétrage des outils de gestion des informations sur la pathologie dans le DHIS2 est réalisé. Pour arriver là, un atelier a rassemblé les acteurs sur le dossier pour définir les indicateurs et outils FO à paramétrer puis s'en est suivi le paramétrage. L'outil disponible va être validé en atelier en 2020. | |
| <ul style="list-style-type: none"> ● Support was provided for the census 69 cases of obstetric fistula and postoperative follow-up of cases operated in 2017; In 2018, 13 simple cases were repaired with the support of MHTF, which contributed for the repair of 26 complicated cases funded by the government. The skills of a gynaecologist (from CHR de Sokodé) were strengthened, during a national campaign on repair of complicated cases, organized in partnership with the “Hôpital Saint Jean de Dieu d’Afagnan”, with an external expert and under funded through Government budget (Ministry in-charge of Women Promotion). ● UNFPA, 2018 template for country annual joint reporting for the MHTF and joint programmes ● FO mini-campaign: Support FO repairs (2 mini-campaigns of 15 women). Achieved ● Identify cases of obstetric fistula: Make a census and follow-up of women operated on during the mini campaigns of 2017. Achieved | UNFPA Togo, MHTF reporting template, 2018 |
| <ul style="list-style-type: none"> ● Du 17 au 22 septembre 2018 a eu lieu au CHR de Sokodé la phase opératoire de la mini campagne de prise en charge des fistules obstétricale (FO) 3ème du genre précédée d’un recensement des cas de FO sur le plan national Cette mini campagne avait pour objectif de : Réparer 10 FO. Assurer la guérison de 90% des cas opérés. Faire le suivi des cas opérés trois mois après l’opération elle a permis aux chirurgiens formé de continuer de s’exercer afin de pouvoir passer à la routine qui aura pour effet de: <ul style="list-style-type: none"> ○ Réduire le temps d’attente des femmes victimes de la FO, ○ D’opérer régulièrement les cas, et ○ Surtout de réduire le coût de la prise en charge d’une FO chez nous | Mini campagne de prise en charge des fistules obstétricales au CHR de Sokodé en septembre 2018 : Rapport technique préliminaire, 2018 |
| <ul style="list-style-type: none"> ● MHTF support facilitated assessments, evaluation and monitoring of existing social reintegration programmes in Benin, Sudan and Uganda, contributing to an evidence base to inform and improve programmes in line with the needs of fistula survivors. | The MHTF UNFPA, Annual Report 2019, 2020 |
| <ul style="list-style-type: none"> ● In 2019, seven MHTF supported countries (Ghana, Guinea, Nepal, Kenya, Nigeria, Somalia and Togo) achieved targets to treat newly identified cases of fistula. | The MHTF UNFPA, Annual Report 2019, 2020 |
| Online Survey | |
| No observations | |

Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build health systems, and community capacity at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors

Indicators:

- Increase in reported progress in all stages of fistula prevention, diagnosis, repair and recovery
- Guidance available to health workers including midwives (prevention, diagnosis), surgeons (repair) and community health workers (prevention and recovery)
- Policies and programmes in place to support rehabilitation of fistula survivors
- Trends in number of fistula survivors who benefit from rehabilitation and reintegration programme and support.
- Examples of community engagement and advocacy regarding the causes and consequences of fistula
- Examples of changing community and health worker attitudes towards fistula sufferers and survivors
- Documented multisectoral approaches which include life skills, nutrition, and social protection especially in the recovery phase
- Examples of concrete integration of fistula strategies into EmONC and maternal health plans and approaches.

Observations

Sources of evidence

Global

- Publishing the **updated Fistula Manual** has called attention to how training is done. In the past, the goal was to train as many fistula surgeons as we can, but as we have seen training without good follow-up or support is detrimental. There is now a shift in thinking – quality not quantity. This is highlighted in the manual.

Interview, International NGO senior manager, September 2021

- “This is **not an exhaustive textbook on fistula care**, but rather functions as a “manual”, aimed at giving a broad view of the issue and practical instruction on fistula programming and treatment. The manual is not specifically about fistula repair, epidemiology, programming, prevention or nursing, but briefly touches on all of these topics and more.”

UNFPA and Campaign to End Fistula, Obstetric fistula & other forms of female genital fistula: Guiding principles for clinical management and programme development, 2020, p.11

Regional

- “Recognizing the **elimination of fistula as key to harnessing the demographic dividend and women’s empowerment**, a strategy on Eliminating Fistula in West and Central Africa (2018–2021) was developed. New “Centres of Excellence” for training were launched in the region to enhance the quality of pre-service education for midwives and nurses. The West African Health Organization and UNFPA strengthened capacities of 18 countries on data for fistula. Seven countries in the region – Cameroon, Chad, Ghana, Mali, the Niger, Nigeria, and Senegal – integrated fistula-related data into their health management information systems.
- A **regional road map towards making pregnancy safer** in Eastern and Southern African was developed and UNFPA and Campaign to End Fistula partners supported country initiatives to end fistula in the region.
- The **Asia-Pacific region continues to battle both obstetric and iatrogenic fistulas**. By 2019, 12 countries in the region had developed road maps to reduce maternal mortality and morbidity, including fistula.
- In 2019, the League of **Arab States, in partnership with UNFPA developed the first-ever regional strategy for Reproductive, Maternal, Newborn, Child and Adolescent Health** that provides member states with a strategic framework to inform national

UN General Assembly, intensifying efforts to end obstetric fistula within a decade, Director General Report, 28 July 2020, pp.6-7

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plans until 2030. A regional study on availability of human resources for emergency obstetric and neonatal care was conducted, **analysing the impact of quality of care in reducing fistula in the region.**"

Bangladesh

- **Perceived relative increase in iatrogenic fistula prevalence and incidence.** There has been a decrease in untreated obstructed labor and, therefore, a reduction in maternal deaths and in obstetric fistula. However, there has been a rapid increase in the C-section rate as a proportion of all deliveries, rising from 9 percent in 2007 to 17 percent in 2011 to 33 percent in 2019. The caesarean section rates reported in the most recent survey are 84 percent in the private sector, 36 percent in public facilities, and 39 percent in NGO facilities. This, along with other pelvic surgeries (e.g., hysterectomies), has resulted in a perceived increase in the incidence of iatrogenic fistula.

USAID, Strategic Assessment of USAID Bangladesh Fistula Programme, April 2019. Accessed from: <http://ghpro.dexisonline.com/reports-publications>

- Support the government to **prepare and implement the OF action plan based on the National Strategy for obstetric fistula elimination**
- Strengthen fistula case identification and referral
- Ensure **quality of care for fistula-affected** women
- Ensure **rehabilitation and reintegration** support for fistula survivors who require support
- Support the government to **generate evidence on fistula and** disseminate findings and lesson learnt for advocacy and policy changes in Bangladesh.

UNFPA, Ending Preventable Maternal Mortality: Country Review and Roadmap for action, 2020, p.4

- In addition, during this time MHTF was also used to work in MPDSR and in fistula prevention programme. In the latter case, **UNFPA organized training of trainers for fistula management**, prepared a pocketbook on fistula and encouraged district level managers in high prevalence districts to focus on fistula elimination measures.

Midwifery Officer, Nursing and Midwifery, Dhaka, Bangladesh, June 2021

- **UNFPA current role is providing technical support to DGHS** to eliminate fistula. The fistula elimination programme works through a divisional approach in three divisions: Rangpur, Rajshahi and Sylhet. UNFPA support consists of funding training for fistula identification, facilitating referral by supporting transportation and surgery costs for disadvantaged group members, developing capacity of surgeons by facilitating their training, supporting income generation training for rehab of fistula victims. UNFPA has also supported the Obstetrical and Gynaecological Society of Bangladesh in setting up a fistula training institute. There is limited interest among other development partners in this area; UNFPA is therefore advocating with the government for earmarking costs for the fistula programme in an operational plan of the sector plan of government.

Health System Specialist, UNFPA, Dhaka, Bangladesh, June 2021

- UNFPA will continue to **work closely with different ministries/government departments** including MoHFW to organize an annual meeting for National Task Force on Obstetric 10,000. Not Achieved. Planned in Q3 and Q4.

UNFPA, 2020 Midyear Report MHTF Bangladesh, 2021, p.2

- The National Fistula Task Force decided to **develop the second National Strategy on Obstetric Fistula** on expiration of the first strategy in 2016. This new strategy will take into consideration the new developments in the field of fistula epidemiology, prevention, treatment, care and management and revise guiding principles, strategic guidelines, goals and targets accordingly. The Directorate General of Health Services has led the drafting of the strategy with support from UNFPA, USAID, its supported Fistula Care Plus Project implemented by Engender Health, as well as the NTFOF. DGHS had convened a series of consultative

MoHSW, National Strategy for Obstetric Fistula 2017-2022, 2018, p.12

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workshops for the inputs of Government, NGO and private professionals for planning the second national strategy. On request from the DGHS, UNFPA engaged an international and a local consultant to facilitate the process.

- **Fistula and other reproductive health related morbidity data** are captured and reported properly from the government and health facilities. morbidities in the DHIS2 system through DHIS2 MIS. DGHS also developed one data collection tool for fistula patients with UNFPA technical support which will be used for reporting through DHIS-2. Moreover, fistula data reporting system has been included in the online cell phone based SRHR surveillance managed by the Institute of Epidemiology, Disease Control and Research of the Ministry of Health and Family Welfare supported by UNFPA. UNFPA will work closely with the National Fistula Centre in Dhaka Medical College and other government and NGO partners to establish a referral model to ensure that all identified fistula cases are referred to available rehabilitation and reintegration programmes. 95 fistula patients will undergo rehabilitation programme in a year. With UNFPA support, World Mission Prayer League (LAMB) Hospital implemented fistula rehabilitation activities in Rangpur Division. The interventions include identification, referral and management of fistula cases, psycho-social and mental support for all fistula patients and need-based rehabilitation and reintegration support for the patients through linking them with other ministries/departments such as Department of Social Welfare, Department of Women Affairs of the Government. In 2019, 109 fistula survivors received psycho-social and mental health support during pre-operative, per-operative and post-operative stages, including during follow ups. Furthermore, 29 fistula survivors received re-integration support from the Department of Women Affairs in Rangpur Division.

**UNFPA, 2019 Annual Report
MHTF Bangladesh, 2020, p.7**

- **To end obstetric fistula, UNFPA assisted Government of Bangladesh to develop National Strategy to End Obstetric Fistula.** Development and standardisation of fistula data recording tool for government medical college hospitals and private hospitals to improve surveillance, development of an awareness-building poster for the fistula to use in the district and sub-district level to prevent future occurrence of fistula and the development of a pocket handbook on fistula for field level health workers for fistula identification, referral and prevention are some of the key achievements. In addition, functional fistula corners in fifteen districts were successfully established in. This initiative will contribute to development of a responsive health system for the prevention of fistula as well as improve fistula identification, increase access to treatment. In 2019, 12,000 women were screened for fistula; of them 900 were identified with genital fistula, 650 were referred to the referral facilities for management and 583 fistula cases were repaired.

**UNFPA, 2019 Annual Report
MHTF Bangladesh, 2020, p.3**

- UNFPA Bangladesh has **organized several technical meetings with MoHFW** at the Bangladesh secretariat on final review of the second National Strategy for Obstetric Fistula (2017-22). Feedback from the meeting has been incorporated by UNFPA and shared with the DGHS. The DGHS has sent the final revised strategy to the Health Ministry for the final approval through the national task force meeting. It is currently under the final approval process.
- Workshop on “**Women with Persistent Fistula Related Disorders**” was organized in Jashore. UNFPA and Engender Health had jointly organized this workshop. Professional expert groups from Dhaka reviewed global standards for managing such cases to build a common consensus on understanding how to define the status of fistula cases for other than surgical management, how to ensure long term health care and how to provide rehabilitation services. This consensus has been called the "Jashore recommendations for women with persistent fistula related disorders in Bangladesh."

**UNFPA, 2018 Annual report
MHTF, 2019, p.3**

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| <ul style="list-style-type: none"> In Rangpur division, Elimination of Genital Fistula by Capturing, Treating, Rehabilitating and Reintegrating in Bangladesh has been started. The divisional level inception meeting followed by a workshop of fistula prevention is organized at the Rangpur division. | |
| <ul style="list-style-type: none"> The availability of quality fistula data contributes to evidence-based development and advocacy to end the condition. By 2018, 16 MHTF-supported countries (Bangladesh, Benin, Burkina Faso, Burundi, Côte d'Ivoire, the Democratic Republic of the Congo, Ghana, Kenya, Liberia, Nigeria, the Republic of the Congo, Rwanda, Senegal, Sierra Leone, South Sudan and Uganda) had integrated fistula-related indicators into the national health management information system, indicating a move towards more standardized reporting of diagnosed and treated obstetric fistula cases, and the tracking of fistula data from facility levels to the national level. | <p>The MHTF UNFPA, Annual Report 2018, 2019, p.24</p> |
| <p>Benin</p> | |
| <ul style="list-style-type: none"> Nous traitons les fistules sous forme de complications entrant dans le cadre des accouchements (ce n'est pas présenté comme une stratégie séparée ; les sages-femmes interviennent dans le volet préventif) | <p>Entretien Ministère de la Santé, Ecole de sages-femmes, Benin, Mai 2021</p> |
| <ul style="list-style-type: none"> Il y a un problème d'insuffisance, voire manque de spécialistes formés pour la prise en charge des fistules obstétricales dans certains centres de réparation initialement fonctionnels et dans certains hôpitaux de zone sanitaire, pour la prise en charge des cas, en mode routine. | <p>UNFPA, 2019 Annual Report - Benin, 2020, UNFPA, New York, USA</p> |
| <p>Sudan</p> | |
| <p>UNFPA practical support to fistula repair</p> <ul style="list-style-type: none"> 90 fistula repair operations were performed during 2020 220 fistula hygiene kits were procured and distributed to facilities providing fistula services. | <p>UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>UNFPA invests in fistula response capacity</p> <ul style="list-style-type: none"> Annual report identified "Minor rehabilitation to Alfashir fistula centre" which includes rehabilitation of the infrastructure, including the theatre, additional equipment and consumables. | <p>UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>Technical focus supported by UNFPA</p> <ul style="list-style-type: none"> Midwifery Trainings Provision of consumables including drugs, gloves, other supplies etc and commodities including midwifery kits Support patient referral through contribution to the cost of transportation which is directly provided to the patients when they arrive at the hospital following referral UNFPA supports the regular quarterly and annual meetings of the MPDSR committee/group UNFPA supports the notification of fistula patients at community based through a weekly clinic and involvement of community leaders. Furthermore, it supports the transportation of patients, and covers all the costs of the clinical tests, operations and post operation care including DSA costs. | <p>Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021</p> |

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| <ul style="list-style-type: none"> • The fistula operation used to be regularly done when the surgeon was there. He was the leader of the fistula interventions in Blue Nile state. Unfortunately, due to personal issues he moved to Khartoum and then travelled abroad. Then the operations stopped for a long time to be restarted this year through a fistula campaign supported by UNFPA. The operations are done now by a consultant visitor from Nyala, South Darfur State. | |
| <p>A happy ending for one fistula sufferer</p> <ul style="list-style-type: none"> • There was a fistula patient diagnosed and operated on by the resident fistula surgeon. The operation was successfully done supported all through by UNFPA although there is no ongoing support to community reintegration after surgery neither by the government nor by UNFPA. The surgeon followed the patient to her family and found that she is divorced. With some community leaders, the surgeon went to her husband to assure him how well his wife was, and that she had recovered from the fistula and could even get pregnant again. Her husband returned to her and within a short time, she got pregnant and was fully attended throughout her antenatal period by the surgeon. She and her husband have a baby boy who they named after the doctor. | <p>Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021</p> |
| <p>Fistula activities national and state 2018</p> <ul style="list-style-type: none"> • Focus on finalizing the Sudan National Strategy to end obstetric fistula in order to have base for resource mobilization. • Establish proper case identification and registration so that the HMIS can accommodate obstetric fistula. • Capacity building of medical doctors and obstetrics and gynaecology skills. • Assessment and analysis of the obstetric fistula situation in the country (from a gender and health perspective). • Community education and awareness creation on obstetric fistula nationwide including to rural regions. Rehabilitate and equip the fistula centres to scale up the number of obstetric fistula repairs. Operationalize of AlFashir Fistula Hospital in 2019. • Support restoration of psychosocial status of those women who have been treated for obstetric fistula. • Potential obstetric fistula surgeons identified and for participation in the International Federation of Obstetricians and Gynaecologists (FIGO) fistula fellowship programme. | <p>UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan</p> |
| <ul style="list-style-type: none"> • The MHTF continued to address the issue of mental health support and social stigma accompanying obstetric fistula. With its support and in partnership with government ministries and Campaign to End Fistula partners, 1,906 women and girls from nine countries (Bangladesh, Côte d'Ivoire, the Democratic Republic of the Congo, Mauritania, Niger, Nigeria, Sierra Leone, Togo and Uganda) benefitted from various social reintegration programmes. MHTF support facilitated assessments, evaluation and monitoring of existing social reintegration programmes in Benin, Sudan and Uganda, contributing to an evidence base to inform and improve programmes in line with the needs of fistula survivors. | <p>UNFPA, MHTF 2019 Annual Report, Sudan. Khartoum, 2020</p> |
| <p>UNFPA fistula activities in 2020: COVID-19 impacts</p> <ul style="list-style-type: none"> • Support to the implementation of community-based identification of obstetric fistula and referral for treatment services. This includes integration of case identification into existing community based SRH interventions. Due to COVID-19 epidemic and constraining context, active case finding was not feasible due to mobility restriction. • Support the fistula repair centre in three states for routine repairs of fistula patients through the provision of surgical repair services and implement a follow up system to assess the 3- and 6-months success rates. The repair operations are progressing | <p>UNFPA, MHTF Sudan Mid-Year report for 2020, UNFPA, Khartoum, 2020</p> |

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| <p>as planned and the follow up will continue in semester two. 80 per cent of the activity is achieved and the remaining 20 per cent will be implemented as part of third tranche. The repaired cases were previously identified.</p> <ul style="list-style-type: none"> Planned support implementation of evidence-based and efficient social reintegration programme for fistula survivors although this is in the early stages and has been affected by COVID-19 related delays. Conduct training of care providers on obstetric fistula treatment (Nurses, sociologist and operation support staff). Conduct annual meetings of national Task Force and the obstetric fistula surgeons, supporters and activists. | |
| <p>Fistula repair impeded by limited capacity</p> <ul style="list-style-type: none"> Midwives need to diagnose and refer Unfortunately, there is no other intervention in this area (fistula) Although there is a qualified surgeon to undertake fistula repair surgery, there is no suitably equipped operating theatre in the hospital. | <p>Interview, Referral Hospital Medical Director, Sudan, 5 June 2021</p> |
| <p>UNFPA partnering with others on fistula</p> <ul style="list-style-type: none"> In 2017, an international obstetrician attended two fistula repair training camps in Darfur and trained 11 consultants on fistula repair. That in addition to the international procurement of fistula repair kits, rehabilitation/equipping of satellite centres, awareness activities and media programming, trainings for religious leaders. Fistula investments build on this in 2018. “UNFPA is leading the obstetric fistula program in Sudan ... aiming to prevent and repair cases of obstetric fistula, and socially reintegrate survivors of this disability in their communities. The program has succeeded so far in treating cases across Sudan: including Darfur, Kordofan, East Sudan, Khartoum and Blue Nile and others. UNFPA, as the leader of the program, in partnership with the MoH, USAID and the Italian Agency for Development Cooperation, over the past 4 years supported the treatment of 1259 women and girls in Sudan.” | <p>UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan. p.1</p> |
| <p>Repairs and re-engagement</p> <ul style="list-style-type: none"> UNFPA supports prevention of fistula by contributing to capacity-building programmes for health workers and at community level through involvement of community leaders and a weekly mobile clinic. UNFPA covered all the costs of the operations, medical treatments, transport, and even the subsistence of patients through the duration of hospital treatment. They covered training costs as well. Regarding re-engagement of patients to community, actually, there is no intervention in this area even from the government. | <p>Interview, SMOH, Ad Damazin, Blue Nile, Sudan, 7 June 2021</p> |
| <p>Increased and flexible mobile repair capacity</p> <ul style="list-style-type: none"> Previously, UNFPA mobilised an international team to train a team of surgeons to do fistula repair (2017/2018). They are based in Al-Fasher, at what is now a fistula repair centre in North Darfur State. In 2020, this team did 115 fistula repairs of which 45 were funded by MHTF. The team has the capacity to move around the country and is a ‘roving team’ by which is meant they are mobile and can travel to where they are needed. MHTF provides some support but also resources drawn from Core funds. Gradually the team should be able to address the backlog of fistula repairs. As prevention improves, fistula should hopefully decline as a risk but that is some time in the distance. | <p>Interview, UNFPA RH Team, CO Khartoum, 17 June 2021</p> |

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| <ul style="list-style-type: none"> ● “Survivors of obstetric fistula in Sudan are overwhelmed with the social and economic instability of decades. Darfur traditionally had the largest numbers of fistula cases in Sudan followed by Blue Nile and Kordofan, due to the combination of lack of access to even basic delivery care as well as early marriage and childbearing this has been further exacerbated by lack of access to services due to insecurity during the height of the armed conflict. The current Obstetric Fistula Data that reported by Darfur SMOHs showed that near to 366 fistula survivors are waiting for surgical repair, we expected that more cases are not discovered yet.” | <p>UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan. p.1</p> |
| <ul style="list-style-type: none"> ● In Blue Nile State, the MoH face difficulties in implementing fistula treatment campaign due to the health condition of the trained surgeon. UNFPA CO in coordination with sub offices in Blue Nile and North Darfur states managed to coordinate with Al-Fasher fistula centre and make the necessary arrangement to bring two fistula surgeons to conduct the campaign in Blue Nile state. The outcome was that 23 fistula cases were operated. | <p>UNFPA, 2020 template for MHTF reporting, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>National: Uganda</p> | |
| <p>Need for fistula treatment services</p> | |
| <ul style="list-style-type: none"> ● Findings from this 2020 study of data from the Ugandan DHS (2016) suggests that Uganda has a big backlog of women to treat for obstetric fistula and there were less women treated than expected in skilled healthcare centres. Although still under the expected figure, the benefit of these treatments is that for every woman treated, eight more would seek treatment for the condition. This would however cost the country a great deal in that the treatment funds would perhaps give more returns if diverted to outreach activities aimed to get women seek skilled healthcare during childbirth. ● The authors estimate that the current lifetime prevalence of vaginal fistula symptoms in Uganda is between 16.3–22.5 per 1,000 women of reproductive age 15–49, putting Uganda highest among African countries. To reduce the prevalence of fistula in Uganda, 29 fistula centres were set up, distributed in 24 districts around the country. | <p>Nannyonga B and Singuli M, Modelling allocation of resources in prevention and control of obstetric fistula in Ugandan women, 2020, PLOS ONE, online</p> |
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| <ul style="list-style-type: none"> ● The burden of obstetric Fistula in Uganda is estimated at 75,000 to 100,000 women with an annual incidence of 1,900 cases. | <p>MoH Uganda, Final Reintegration Assessment Report, 2019</p> |
| <ul style="list-style-type: none"> ● “There is a downward trend in reduction of the estimates of the prevalence of fistula as indicated in the UDHS surveys. This has been possible through support from UNFPA and key Global and National partners including USAID/Fistula Foundation, | <p>UNFPA Uganda, MHTF Annual Report, 2018</p> |

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AMREF, Terrewode, World Vision, Women at Work International (WAWI), Medical Teams International (MTI) and Uganda Village Project have been fundamental in this Campaign and progress towards eliminating fistula in the country.” (p.4)

| Estimates of fistula in Uganda by UDHS | | | |
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| Year | 2006 | 2011 | 2016 |
| % Prevalence | 2.6% of women of reproductive age | 2.0% of women of reproductive age | 1.0% of women of reproductive age |
| Estimated cases (Backlog) | 200, 000 | 140,000 | 75,000 |

- 1,828 repairs were done for 2018 with support from partners, **with 65 per cent (1,188) supported by UNFPA/MHTF funds.** These camps and routine repairs were done in 21 facilities i.e. Mulago National referral, regional hospitals and selected Private Not for Profit facilities. The camp-based repair campaigns may need to continue as the country progresses in implementation of the RMNCAH investment plan given the very large backlog of women with fistula.

Services via fistula camps

- **Funds for Fistula Camps** were disbursed to seven Regional Referral Hospitals of Arua, Hoima, Mbale, Mubende, Lira, Virika and Soroti Hospitals, and Mulago National Referral Hospital. During the camps, continued mentoring of new Fistula surgeons is ongoing to build capacity of local surgeons.
- **Supportive supervision visits** were conducted to seven regional referral Hospital Fistula treatment sites in Q4 by the MoH Clinical Services Department to ensure quality services especially follow up and linkage services for the survivors and also to ensure continuity of services.
- **Fistula care training** conducted in December 2018 for 26 Nurses and midwives from 13 Hospitals
- Collaboration with National Medical Stores (NMS) to **develop a local kit** postponed to 2019
- Terrewode facilitated activities that supported assessment of 400 Fistula **Survivors Community social re-integration** identifying their individualized reintegration needs, prioritize and addressed them. Activities included:
- **Health facility level assessment in seven Hospitals by the psychosocial support staffs** in collaboration with Health workers in the regional referral hospitals of Masaka, Mubende, Mbale, Arua, Lira and Soroti and Mulago National Referral Hospital
 - **Community level assessments to identify survivors** that have already been treated and discharged through village health teams (VHTs) and OFAAN members, a network of fistula survivors.
- UNFPA Uganda achieved 100 per cent of its workplan objectives for fistula, i.e.,
 - **Coordination:** Conducted quarterly Fistula TWGs; conducted a round of supportive supervision to 8 repair camp sites; conducted commemoration of IDOF and Fistula Walks
 - **Service delivery:** Supported 11 hospitals to conduct fistula repair camps in Q4 for 339 fistula clients
- “A total of 1,468 women have been treated in the National, Regional and selected general hospitals during the year of which over 60 per cent were directly supported by UNFPA and 16 health workers in the regional referral hospitals were mentored in

UNFPA Uganda, UNFPA-MoH Annual Workplan Progress Report, 2018

UNFPA Uganda, GoU/UNFPA Country Program Support to MoH 2019 Annual Work Plan, 2019

UNFPA Uganda, Final Annual Report for MHTF, 2020

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| <p>fistula surgery. With this funding, fistula activities were monitored and tracked through the Quarterly coordination meetings and technical support supervision of the different Hospitals.</p> <ul style="list-style-type: none"> • With funding from this programme, the ministry was able to hold a successful commemoration of the International Day to end Obstetric Fistula with a televised event of an Online Webinar on the National Television, Mass Mobilization campaigns to sanitize Communities about Fistula and the repair opportunities as well as the drop in repairs at Designated Sites (Hospitals) as well as the Repair Camps.” (p.4) • “UNFPA mobilized more resources from Sida under the UN Joint Programme on GBV and the EU-Spotlight initiative to support 18 Fistula repair camps by 14 Hospitals and social reintegration. The 14 facilities that conducted the fistula camps include the following: 1 National referral hospital, 9 Regional Referral Hospitals (RRH) and 4 General/ PNFP Hospitals. However, due to COVID-19 pandemic prevention and control guidelines (set up by the Government/MoH) that limited movements and gathering of people, the planned fistula repair camps were delayed.” (p.8) • UNFPA estimates that in 2022 they will support 3,000 repairs so as to reduce the backlog. | |
| <ul style="list-style-type: none"> • “UNFPA support to fistula camps has filled a critical gap and helped women suffering from this condition, since fistula prevention, care and treatment is not part of the routine package of services at health facilities and, thus, not adequately funded by the government.” | <p>Interview, MoH Uganda, May 2021</p> |
| <p>Capacity building for fistula treatment</p> <ul style="list-style-type: none"> • MoH has the technical expertise and capacity at the national level – and they are supervising/mentoring the RRH – who has a lot of fistula experts. At the national RH down to the regional RH – so we have experts all over, very experienced all over the country. And we have some experts in private not for profit hospitals – like the big hospital in Gulu (St. Mary’s Lacor Hospitals). • Transitioning to a routine model would require that you have the equipment, a team that is dedicated and there to do these operations. “A special theatre is not a “must” – but to keep this a routine, it would be nice to have the space – when the women come, you work on them as they come in – without disrupting other essential services. When you go to Kawempe National Referral Hospital – they are so busy doing emergency operations. When you have an emergency, you deal with that, rather than treating a patient who can wait for another women.” • Not all obstetricians can do fistula repair; there is not a strong national training centre for fistula; most surgeons go to Ethiopia. A lot of learning comes in through the fistula camps given that very few dedicated centres that do just fistulae on a routine basis. Terrewode is a dedicated centre. Regional Referral Hospitals do not offer routine repair except for Mbarara Teaching Hospital. UNFPA MHTF supports that hospital through MoH – only repairs, not reintegration. | <p>Interview, UNFPA Uganda national staff, May 2021</p> |
| <p>Service provider perspectives</p> <ul style="list-style-type: none"> • The hospital started its fistula programme in 1990 by an Irish doctor who mobilized funds from the US, Ireland, and other countries to support camps servicing 60 or more women at time. EngenderHealth provided significant support through the MoH for a comprehensive package of fistula prevention, repair, and social re-integration, but the funding ended in 2017. • UNFPA provides support to the hospital to organise fistula camps. Due to COVID-19, only one camp was organised last year, in October 2020. The funding covers awareness creation, transportation of the women to the hospital, feeding during hospital | <p>Interview, Private, non-profit service provider, Masaka District, Uganda, May 2021</p> |

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stay, materials and commodities, and the DSA of the fistula surgeons coming from other places. “The money was very, very helpful, because as you know, prices have gone very high here in Uganda. It helped a lot, especially in terms of paying for the transport of patients going back home.” **UNFPA does not provide any funding for social reintegration in this site.** “Adequate funds for reintegration is a big gap.”

- The **main challenge in shifting from camp approach to routine services is lack of specialised fistula surgeons** and other medical staff. To build capacity, they normally invite medical officers (MO) and nurses to come and assist the “specialist team” to learn from them how to repair fistulas, but also how to prevent iatrogenic fistulas caused by injuries during C-sections. “Transitioning to routine repair would be better, so that the trainees could come here and learn. But we do not have sufficient funding to organize a workshop to train those “external” medical officers and interns.”
- There is a clear **system for following up on women once they have left the hospital, i.e. through phone calls and a 3-month check-up.** “The follow-up is done on the phone – we give them cards on discharge, with our numbers, we tell them, move with your card, when you get pregnant, move with the card. The card has all our phone numbers, my number, the nurse etc. They can call and tell us if they have more leakage, pain or other challenges, and then they can come back – or we direct them to nearest health centre (HC), and we talk with the HC, those nurses call us, inform us about the problem seen, and then we advise and help them have the treatment. If not helping, we ask them to come back, we have funds for that.”
- **Identification of women who need fistula repairs is usually through “mouth-to-mouth”** – women who come back from fistula camps and have been successfully repaired, tell other women that the next camp is in 3 months. Health facilities also refer women with fistula to the different camp sites. Awareness and demand creation is also through **national and local radio, community-outreach,** and mouth-to-mouth.
- According to the provider, the following are the trends in fistula: “The **cases caused by obstetric labour are fewer**, in those coming in today. It could be that most of them have been cleared, repaired by now. We do not find those cases who have had a fistula for long. Also, there are **fewer patients who said we have had fistula for 15-20 years**, it is no longer the story – that means that they get repaired earlier. Could be because the efforts we have made. Referral hospitals are more active, meaning there are less cases of obstructed labour. There is a conservative management now, **if a woman in obstructed labour for 2 weeks, action is taken. Supervision and mentoring have improved.** The only challenge we have is to reduce what we are having – that could be done with more training and skills development. We could and should teach others how to do safe C-sections.”

- **Fistula repair should be routine; however, there are logistic challenges to do that** – unique equipment and supplies, including tents. Support is also needed for reintegration. “We can treat three to five cases per week, but only if we hold off other surgeries (vasectomies etc.) – otherwise, we can only do camps. So normally, we do not do more than one to two per day. The women stay for long.”

Interview, Service provider, Kampala, May 2021

- There are **several barriers to routine fistula repairs.** First, **it is a resource heavy undertaking**, and second, there are **still issues of human resources.** “We do not have fistula surgeons all over these places. Two, equipment, we do not have equipment all over these places, all the public facilities. Three, fistula affects the poor.” Women have to been given money to come, to stay

Interview, UNFPA staff, Kampala. May 2021

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two weeks in hospital, and to go back home again. And those two weeks, without personal economies, it becomes hard (i.e. no feeding). Resources are needed for 40 women, and that will be able to cover for commodities and supplies for the operations – then they can mobilize a team of fistula surgeons who can come and organize the camp – they bring in other surgeons from other facilities – there has to be a team of at least four to five people for one camp. So, when they collect those few resources, they can organize a camp.

- At the national hospital, **“a special theatre is not a “must” – but to keep this a routine, it would be nice to have the space –** when the women come, you work on them as they come in – without disrupting other essential services. When you go to Kawempe National Referral Hospital – they are so busy doing emergency operations,” as opposed to elective cases that can wait without any risk to the patient.

Shifting focus to reintegration of fistula survivors

- The **2020 plan includes an intervention to support evidence-based social reintegration/rehabilitation for fistula survivors** (costed plan, monitoring, reporting, cost-efficiency evaluation). According to the annual report, the obstetric fistula social rehabilitation programme is available and monitored; however, **it is “run by CSOs and not yet integrated into the government structures.** Evaluation of the reintegration programme was done to inform the new strategy.”

UNFPA Uganda, Final Annual Report for MHTF, 2020, p.12

- **“Three service packages constitute fistula care, namely prevention, treatment and reintegration.** Reintegration refers to a deliberate approach during which fistula survivors or those with fistula deemed incurable are given social, psychological, medical and economic support to enable them settle back into the community. Interventions are at facility and community level. **The Community based reintegration package recommended by the MoH provides counselling, community sensitization, linkage to VHTs, economic empowerment, follow up, involvement of fistula champions and life skills training. At facility level, MoH recommends reception of clients, counselling, needs identification, psychotherapy, co-morbidity management, accommodation, financial support (feeding, transport fares), referral to CBOs, life skills training, information on income generation in addition to timely repair** while at facility level. Despite these recommendations, implementation reintegration package has continued to lag behind as highlighted in The Mid Term review of UNFPA’s Campaign to End fistula, which further recommended more attention to reintegration with dissemination of good practices, lessons learned, challenges and opportunities for future programming.” (p.7)
- The **MoH conducted an assessment to determine the status of implementation of the reintegration package** and develop facility and community models for wider adoption in future interventions and advocacy by the MoH and its partners. A total of 11 health units participated in the assessment: Mulago National Referral Hospital, St. Mary’s Hospital Lacor, St Joseph’s Hospital Kitovu, and the referral hospitals of Soroti, Lira, Mbale, Jinja, Mubende and Fort Portal. Two community-based organizations participated: TERREWODE and Uganda Village Project (UVP).
- The **reintegration package was guided by WHO reintegration** principles and outlines services to be offered at facility and community levels and emphasizes the linkages between these levels.
- Results of the assessment included:

MoH Uganda, Final Reintegration Assessment Report, 2019

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- A total of 4,813 fistula repairs took place across the participating facilities in the past 5 years, with TERREWODE contributing 34%.
- There are 279 staff involved in provision of fistula services, but only 20 per cent received some form of training on reintegration.
- Counselling, medical management and reception of clients were the best performed services at facility level, with over 75 per cent of clients receiving each or all of them. Skills support (20%), financial support (30%) and psychotherapy (30%) were received by the least number of clients. Only 13 per cent of respondents received more than half of the services in the facility package.
- The vast majority (89%) were satisfied with integration services at facility level while 55 per cent rated community-level services as poor or fair. Only Kitovu Hospital, UVP and TERREWODE were involved in reintegration services beyond the facility, with TERREWODE accounting for 70 per cent of clients supported at the community level.
- The assessment recommended that: Individual and family counselling as well as community sensitization would go a long way in improving the psychological aspects of coping with fistula. Capacity building for health workers especially in the entire reintegration package would enable better quality of services. The capacity building should also stretch to the community where Village Health Team (VHT) members could play a critical role in follow up and community level psychosocial support. However, there is a limit to this as a lot of clients come from outside the catchment areas of the various facilities. At all levels, there is need to integrate as much as possible with other services.” (pp. 8-9)

Additional recommendations:

● **Relevance:**

- Efforts should be made to involve all ministries and other stakeholders with relevant roles to play in fistula reintegration
- Reintegration programmes should be designed to socially, psychologically and economically benefit all patients.
- Both facility and community reintegration should be strengthened because they have a significant and complementary role to play at different times during the reintegration process.

● **Effectiveness:**

- MoH and other stakeholders should advocate for more resources to support reintegration,
- Surgical care services should work hand-in-hand with other stakeholders to include reintegration

● **Efficiency:**

- Clients should be oriented to needs identification and be given feedback about findings that exclude them from economic empowerment activities.
- Clients should be given minimum start-up capital to ensure that resources can be spread among a larger number of clients

● **Impact:**

- Increase male involvement through community sensitization
- Strengthen linkages between health facilities and CBOs

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| <ul style="list-style-type: none"> ● To achieve sustainability, reintegration services must be integrated into the existing health care package and ownership by government and community enhanced. | |
| <ul style="list-style-type: none"> ● “Most of the resources have been going to the repair to be done – and reintegration is one of the areas that still needs more funding, to see that this reintegration happens, across the board, including the public facilities. At the public facilities, that component is not strong – no funding. The PNFP have some small puts of funding – some pigs are given to the women, some skills building.” | <p>Interview, UNFPA Uganda national staff, May 2021</p> |
| <ul style="list-style-type: none"> ● UNFPA has contributed to increasing access to fistula treatment and social reintegration through funding for fistula camps, support to develop the national fistula strategy, and funding of Terrewode for reintegration projects. UNFPA has supported the fistula technical working group (TWG) and fistula camps, as well as social reintegration (through the NGO Terrewode). There is a huge funding gap for fistula – often considered the “orphan” technical area. Shifting from camp based to routine-based fistula care and treatment is challenging as it requires continuous training/capacity building of health care providers to be able to perform fistula repairs, as well as significant investments in infrastructure, equipment and infrastructure. ● Different partners support reintegration: therefore, MoH and UNFPA wanted to “standardize” this reintegration support as reintegration mean different things for different IPs. “It was important to develop a standard package, and review this package with MoH, to ensure when we talk about reintegration, we understand the same thing. Reviewing this package, what it entails, what it costs – will be a focus of this year (2021). It will also be a very good resource mobilization – if you have 50 women, how much will it cost to reintegrate them – it will be important and useful when we lobby for funds with our donors. I was excited myself to see that the Kitovu hospital, that we just visited, had some kind of reintegration. It is very thin on the side of the government facilities. At least we should have a minimum package. Even if you have repaired them successfully, they might still have psychosocial issues that need to be resolved, they will need a lot of economic support, to gain a living.” ● MHTF support to Terrewode (East Region) is for reintegration – in both Kampala and the Soroti sites. (The surgery is done only in Soroti). The MHTF funds for Terrewode go through the MoH – not to Terrewode. “The work that goes in to having that understanding is with MoH – Terrewode is a small organization and has been at the forefront of coming up with these reintegration strategies. But I do not think they have ever applied to become an IP from UNFPA - the call went out, but they did not apply directly with us. For fistula, the funds only go to MoH – for reintegration (Terrewode) and camps (MoH sends to the hospitals).” | <p>Interview, UNFPA Uganda staff, May 2021</p> |
| <p>Model for reintegration (and holistic fistula services)</p> <ul style="list-style-type: none"> ● UNFPA has funded Terrewode, through MoH, for over a decade. UNFPA has supported both camps and reintegration (for the last 7 year). UNFPA has supported both prevention, treatment and care, and social reintegration, but they did not receive any UNFPA funds last year. This year, they are expecting to receive UNFPA funds through MoH for social reintegration only. ● Terrewode has been active in fistula for the last 20 years, starting with awareness creation at community level, long before UNFPA began their programme. Collaboration was started with UNFPA in 2007 or 2008, when UNFPA started their country programme in Uganda. At first, collaboration was informal. All funding comes through the MoH, both for reintegration and camps. It has been a long-term relationship, but the MOU is not directly with UNFPA, but with MoH. Terrewode also received | <p>Interview, NGO partner, Uganda, May 2021</p> |

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funding from EngenderHealth until 2018. The funding included research on how to support women who are “incurable”, i.e., cannot be cured for fistula (approximately 1 per cent) and it has some preliminary findings, not yet published. “These women are there now – we do not have funding to help them. It was a beautiful piece of work, it found out that social reintegration can help those women, but it requires more resources, more tailored approach, than those women who get treated.”

- **Terrewode uses a holistic approach to address the issues of obstetric fistula**, which has been developed over time based on the experiences and lessons learned. “But we were not able to achieve all this, until we established the Terrewode Women’s Community Hospital providing care to mothers with birth injuries, obstetric fistula, different tears, prolapse etc. So, it is specialised in providing that.
- We have two arms: **Community outreach arm** collaborating with health facilities and other partners like UNFPA to support community awareness, treatment and reintegration. The other arm, which is piloting some practicing for routine care – is it possible that you can **provide routine services** – how can it be done, what does it cost etc.? We are still piloting that. We want to share with the other partners through the TWG for fistula. I think it will inform us which kind of resources you will need to provide routine fistula treatment and care. What does it cost, what impact can it have for the women who are treated and reintegrated, and also, does it actually increase the number of fistula experts in the country.
- We also **hope to provide training to junior upcoming doctors**, providing hands-on mentorship on very specialised aspects of fistula care and other birth injuries. But broadly, the NGO arm (the first arm) continues to engage communities on broadly MCH. When you talk about obstetric fistula, but we also address the primary causes, the line causes, like teenage pregnancies, and how they can expose the teenagers and make them vulnerable, either they die in childbirth, or they have birth injuries. So, we provide a comprehensive package. We work with health facilities and VHTs, we are adding our contribution to national efforts (of the MoH) which are aimed at contributing to global efforts to improving health and SRHR broadly.”
- When asked about trends in fistula, the respondent, noted that patients come in earlier. Previously, there was a high number of women who have lived with the condition for more than 10 years. **Cases are increasing among those who are handled within 12-24 months, and still a very few of those with very long-term conditions.**

Zambia

UNFPA support for fistula repair services (camps)

- **Education campaigns supported by partners have alerted more women, families, and communities to the importance of obstetric care as well as the specialized surgery available to help them. Currently, six hospitals offer routine fistula treatment; nine fistula surgeons have the skills to offer repair as compared to a decade ago with only two hospitals and two surgeons. More than 300 patients undergo fistula repair annually, most through outreach camps.** Camps contribute to having more fistula survivors access treatment while serving to mentor other doctors to strengthen surgical skills. The MoH plan is to institutionalize fistula treatment at all provincial hospitals.

Kasunda, G. Obstetric Fistula in Zambia. Undated.

- In collaboration with the Fistula Foundation, **UNFPA supported 185 fistula repair surgeries.**

UNFPA, Zambia. 2019 Annual Report. 2020

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| <p>Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors</p> | |
| <ul style="list-style-type: none"> UNFPA and other partners have supported Luapula Province for the past nine years to provide fistula operations via camps. The 2020 camp was sponsored by UNFPA at Manza General Hospital; 24 clients were mobilized from districts both within and outside the province, including Luwiny, Serenje, Kitwe, Cilubi, Kawambwa, Samfya, Chitambo and Nchelenge. Clients were mobilized one week prior to the camp by community-based volunteers collaborating with the facility. | <p>Mwanza, M. Report on Fistula Surgery, Manza General Hospital, Luapula Province. 2020</p> |
| <ul style="list-style-type: none"> UNFPA supported a fistula surgical camp at Mansa General Hospital in collaboration with the Fistula Foundation. Thirty-five clients (35) clients were mobilized from 12 different districts in Zambia, drawing most from Cheingi District. Two visiting surgeons from Kusaka and Mpika were invited to provide technical and supportive supervision to the local team. Two off-duty nurses were mobilized to assist as there was an inadequate number of staff working during the camp. The camp was reported to be a success and well-coordinated; theatre staff worked well with no challenges and the visiting doctors interacted and worked well with the local team. Few challenges were encountered. A total of 35 clients came to the camp and 29 underwent surgery, with the last patient discharged after 2.5 weeks. | <p>Mulembwe, Daniel Mutale. Report on Fistula Surgery, Mansa General Hospital, Luapula Province. 2019.</p> |
| <ul style="list-style-type: none"> Two hundred and twenty (220) women with obstetric fistula were repaired in 2018 with UNFPA support. | <p>UNFPA Zambia. Annual Report-2018-2019. 2019.</p> |
| <ul style="list-style-type: none"> During camps, UNFPA supports the treatment, the feeding of fistula patients, and the provision of the necessary equipment and supplies, which may not be in the system. “I would love it if they can provide more support except that they have limited funding. Three or four treatment camps are held within a year and before they used to support more than that, but I think because of limited funding, they are supporting less of those treatment camps. In terms of reintegration and rehabilitation, I think this is why we still have the big challenge in terms of not having a very well organized system that rehabilitates or reintegrates patients with fistula. I think we have not done much in terms of the rehabilitation of those patients; particularly those patients who cannot have successful treatment of the fistula.” | <p>Interview, MoH Service provider. Lusaka, Zambia. August 2021.</p> |
| <ul style="list-style-type: none"> “For UNFPA, Fistula remains top on the agenda – strengthening EmONC so that fistula does not happen in the first place. We prioritize identification of clients and being able to support the camps on where they are being done.” | <p>Interview, UNFPA Zambia national staff. August 2021.</p> |
| <p>Fistula Prevention</p> <ul style="list-style-type: none"> UNFPA has been effective in fistula prevention and care because of the way the programme has been done. UNFPA did a good job in sensitizing communities so that women who have been secluded for as long as 15 to 30 years have come out to access services. One such woman said, “I did not believe that I could even socialize with people.” | <p>Interview, MoH Zambia national staff. August 2021.</p> |
| <ul style="list-style-type: none"> “Solving the problem of fistula is twofold, preventing fistula and repairing fistula. By sharpening the skills of midwives so that they can be able to tell when a delivery could lead to fistula and therefore, they can prevent fistula during delivery; for instance, by recognizing quickly that the baby’s position is such that it may lead to complications and consequently cause fistula. The midwives can make quick decisions to deliver the baby as quickly as possible or to consult experts at the next level facilities. We have recorded some successes in some cases, where the midwife conducts a complicated birth through instructions from a specialist by phone. If necessary, the midwife can make a decision to transfer the patient to the next level facility. If the fistula | <p>Interview, MoH staff. Western Province, Zambia. August 2021.</p> |

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| <p>has already occurred, we bring these women to a health facility where they can be worked and then they can be integrated back into their communities.”</p> | |
| <p>Shifting from camps to routine services on demand</p> <ul style="list-style-type: none"> ● Most of the repairs are done through camps. For the future, the aim is to institutionalize fistula repair in UNFPA supported provinces and nationally by looking at how to build capacity in surgeons so that they can do fistula on demand. “Institutionalization is happening with a couple of surgeons, deliberately – whilst proficient surgeons are learning on the job – registrars in training, attached to surgeons. As we speak, we have put in our plan, we propose to train two surgeons to train with proficient surgeons in Kenya. We are looking at this as a long-term solution. The issue we may have to grapple with – the usual problem of movement/attrition of staff. The surgeons-in-training would stay to carry on with these works.” | <p>Interview, UNFPA Zambia national staff. August 2021.</p> |
| <ul style="list-style-type: none"> ● The policy is in place to support the institutionalization of the treatment of fistula by obstetricians; however, when it comes to implementation, it is a challenge to focus on training of postgraduate and graduate students in Obstetrics. “Institutionalization of fistula treatment requires that you have specialists who are able to operate in all these provincial positions, but we do not have this yet.” ● “We have an opportunity in the sense that all the provinces have at least one obstetrician and this is an opportunity for realizing the policy on the institutionalization of fistula treatment in Zambia.” | <p>Interview, MoH service provider. Lusaka, Zambia. August 2021.</p> |
| <p>Tracking/follow-up of fistula clients</p> <ul style="list-style-type: none"> ● The purpose of this mission was to check on the well-being of fistula survivors operated on in 2019 and to introduce and use SMAGs in the tracking and identification of fistula clients. ● The tracking incorporated the use of 15 SMAGs; training included: <ul style="list-style-type: none"> ○ What is obstetric fistula, how it is caused, signs and symptoms ○ Complications of fistula ○ SMAGs role in prevention of fistula through encouragement of institutional deliveries, identification of fistula clients in communities, and referral of fistula clients to health facilities ● A total of 12 clients were tracked from 5 districts (Kalabo, Mongu, Shangombo, Senanga and Kaoma). All clients had shown signs of healing well. ● Lessons learned: <ul style="list-style-type: none"> ○ Involvement of SMAGs increased community participation in case identification and referral of clients ○ Reviewing clients in their own homes by health workers resulted in confidence in the facility and the care received. | <p>MoH, Zambia, Western Provincial Health Office. Report on tracking of fistula survivors. 2019.</p> |
| <ul style="list-style-type: none"> ● UNFPA supported a tracking exercise in 2020 to follow-up fistula clients in Mongu, Shagongo, Shesheke, Mulobezi, and Senanga Districts in order to: <ul style="list-style-type: none"> ○ Establish the outcome of the repairs and rebook those who had an unsuccessful repair ○ Identify new clients and book them for repairs. ● Lessons learned: <ul style="list-style-type: none"> ○ Involvement of SMAGs in the tracking provided them with a greater understanding of fistula | <p>Mayatola, Cathrine. Report on tracking Fistula Survivors, Western Province. 2020</p> |

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| <ul style="list-style-type: none"> ○ Visiting clients helped to identify new cases in the community and book them for repair. ○ Tracking of clients through their families and phones facilitated their identification. | |
| <ul style="list-style-type: none"> ● A follow up of post-operative fistula survivor clients was done in Chiengi and Nchelenge districts in November 2018 and a total of 35 clients (out of a target of 40) were tracked and interviewed. ● The follow-up was facilitated by the involvement of the District Health Directors from the districts visited and the community health volunteers. ● Recommendations from the exercise include: <ul style="list-style-type: none"> ○ Need to link post-operative fistula clients with nearby health facilities for continuous care ○ Clients need to receive information on where to access health services following surgery ○ Continue to increase community awareness for general public to explain the cause of fistula to promote acceptance in the community and families. ○ Link clients to traditional and civic leaders to facilitate Social Cash Transfers, given that majority are single, divorced and financially poor. | Mulembwe, Daniel Mutale. Fistula Tracking Report, MoH, Luapula Province. 2018. |
| Reintegration <ul style="list-style-type: none"> ● With regard to reintegration, the plan is to explore an avenue to collaborate with other ministries to address reintegration and social impact. The route to take is partnership with line ministries that have the capacity to help with re-integration. Ministry of Community Development and Social Welfare – has a unit that looks at social cash transfers. It begins with an assessment of vulnerable members of the community who can be helped with cash so that they can be stabilized. Social Welfare Officers in the district – it will help identify fistula clients/survivor and then support them to start-up businesses in the community. These women are vulnerable because they lost their marriages because of fistula. | Interview, UNFPA Zambia national staff. August 2021. |
| Online survey | |
| No observations | |
| Assumption 4.3: MHTF is an effective platform to host the <u>Global Campaign to End Fistula, enabling harmonisation of strategies, activities, advocacy and financing</u> to deliver results on fistula more efficiently than either approach would alone | |
| Indicators: | |
| <ul style="list-style-type: none"> ● Examples of increased political commitment, national leadership and ownership and financial mobilization linked to campaign activities (i.e., International Day to End Fistula, 23 May) ● Examples of improved knowledge sharing and collaboration among global campaign partners. | |
| Observations | Sources of Evidence |
| Global | |
| <ul style="list-style-type: none"> ● “In 2016, United Nations Secretary-General Ban Ki-moon called upon the world “to end fistula in a generation”. This vision and goal were further strengthened by a resolution on ending fistula passed in the United Nations General Assembly in late | UNFPA, MHTF Business Plan Phase III (2018-2021), 2018, p.41 |

Assumption 4.3: MHTF is an effective platform to host the Global Campaign to End Fistula, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone

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| <p>2016. As the leader of the Campaign to End Fistula, UNFPA is coordinating partners and stakeholders to develop a global action plan.</p> <ul style="list-style-type: none"> ● “Contributing to the Campaign to End Fistula, the MHTF will particularly focus on strengthening the capacity of governments to develop, implement, and monitor an evidence-based national strategy for ending obstetric fistula, founded on three pillars: prevention of new fistula cases, treatment of existing fistula cases, and social reintegration and support for fistula survivors. The goal is universal access to this holistic spectrum of care for every woman who needs it. Fostering and supporting national leadership and ownership is key to ending fistula.” | |
| <ul style="list-style-type: none"> ● With minimal resources, UNFPA has really helped with awareness-raising for fistula as they have put their name/recognition behind the International Campaign to End Obstetric Fistula. They use the UNFPA megaphone and advocacy role to encourage contributions across partners and countries in the treatment landscape. Prior to this partnership, the information on who was funding/implementing fistula programmes was very limited. Awareness-raising is the biggest contribution that the Campaign has made, especially the work done through the UN and the Secretary General. | <p>Interview with International NGO staff, September 2021</p> |
| <ul style="list-style-type: none"> ● UNFPA launched the Campaign to End Fistula in 2003. It was not always hosted under MHTF; and now, it is not fully folded in as there is a separate fund for the campaign, even though the MHTF staff manage it. Reporting on the campaign is now integrated into MHTF reporting. Funding for the campaign is small compared to the resources available for fistula under the MHTF. ● Because UNFPA leads the campaign, communications and visibility are really critical. It is a big challenge if UNFPA wants to move forward. There is both high external and internal expectations for the campaign to be successful; however, the communications position has been dropped. While there is a need for visibility of the campaign, MHTF also needs visibility. This compounds the problem. Visibility needs to be strengthened for both the campaign and MHTF. The UNFPA system for resource mobilization is set up in such a way as to create competition among different thematic areas, such as UNFPA Supplies and Humanitarian, plus core funds/institutional budget. MHTF is important but not a top priority. | <p>Interview, UNFPA staff, February 2021</p> |
| <ul style="list-style-type: none"> ● Several years back, 2014, the campaign coordinator at that time left very suddenly, from one day to the next. A lot of people was asking what happened, it was a fragile time for the campaign and for UNFPA. However, over the years UNFPA has solidified and strengthened its leadership role when it would have been easy for the campaign to “fizzle out” or fade into the background. UNFPA receives a lot of positive feedback from partners, UNFPA is seen as a global leader in the area, and countries contribute a lot to that. UNFPA is clearly a leader on obstetric morbidities. | <p>Interview, MHTF staff, February 2021</p> |
| <ul style="list-style-type: none"> ● “Evaluation of the work on obstetric fistula is a bit of a unique, exceptional case as far as the MHTF goes. While fistula programming in countries (and regions) is one key piece of the work, UNFPA's leadership of the global Campaign to End Fistula is a related, yet distinct piece. The Campaign is both part of the MHTF and goes beyond the MHTF. UNFPA has a mandate from the UN Secretary General and the UN member states (as per the Secretary General reports (which UNFPA is tasked by the UNSG office with writing) & UN General Assembly Resolutions shared with the evaluation team) to lead the UN system response to obstetric fistula. ● And the UNFPA-led Campaign to End Fistula is comprised of a multitude of global partners (nearly 100), with UNFPA clearly driving the global vision & agenda on fistula, convening the global Obstetric Fistula Working Group, etc. | <p>Written communication from MHTF staff regarding comments on Inception Report, 22 April 2021</p> |

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| <p>Assumption 4.3: MHTF is an effective platform to host the <u>Global Campaign to End Fistula, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone</u></p> | |
| <ul style="list-style-type: none"> The Campaign also supports all 32 MHTF-supported COs, but another 20+ in addition. So, it would be important to look not only at the fistula work in 32 MHTF countries, but to look at the holistic "big picture" of UNFPA's global leadership on ending obstetric fistula. Else, we risk looking at only a fraction of the whole fistula work and "short-changing" the MHTF & UNFPA for the leadership & accomplishments on fistula." | |
| <p>Regional</p> | |
| <ul style="list-style-type: none"> No observations | |
| <p>National: Bangladesh</p> | |
| <ul style="list-style-type: none"> The Islamic Development Bank (IsDB) and UNFPA/Campaign to End Fistula on 13th March 2018 co-hosted a panel discussion entitled "Preventing the Preventable: Reaching Rural Women and Girls through Obstetric Fistula Initiatives" - Improving rural women's access to maternal health services contributes to significantly protect them from being susceptible to preventable maternal morbidities. The panel focused on innovative approaches through obstetric fistula initiatives being used by partners to reach rural women and girls, while raising awareness on high potential OF eradication efforts, exploring evidence, experiences (from Bangladesh and Afghanistan), opportunities and challenges for scaling up OF efforts and getting OF related prevention and comprehensive treatment services to rural women. The importance of partnerships and coordination were reiterated as critical in improving the effectiveness in advancing OF eradication efforts. | <p>UNFPA, Campaign to End Fistula Newsletter - April 2018, p.3</p> |
| <p>Uganda</p> | |
| <p>UNFPA support for International Day to End Obstetric Fistula</p> | |
| <ul style="list-style-type: none"> The theme of the 2020 International Day to End Obstetric Fistula (IDEOF) was "End gender and health inequalities; End fistula now." Partners included USAID, WHO, AMREF, Fistula Care Plus (EngenderHealth), Terrewode, Medical Teams, Uganda Village Project and CoRSU. The objectives are to raise awareness about causes, complications, prevention and treatment of obstetric fistula; advocate for communities to support reintegration of fistula survivors; strengthen maternal health partnerships at all levels; and advocate for continuity of SRHR services amid COVID-19 pandemic. Activities included a live webinar broadcast on TV, Facebook and Twitter; radio advertisements and talk shows; spot adverts on TV, community sensitization using film vans and loudspeakers; printing and distribution of IEC materials, i.e., t-shirts, banners and flyers; and a newspaper supplement. It was estimated that 500,000 Ugandans were reached via these activities. Issues that arose: <ul style="list-style-type: none"> Inconsistent and outdated data is still being used (2016). Some facilities do not have formal data collection tools (HMIS) for fistula. Mothers were not accessing health facilities for EMOC services easily during the lockdown and lacked adequate transport means (ambulance). Some HCIVs do not have functional theatres so mothers may have to move long distances to access C-section services hence contributing to the delays. | <p>UNFPA Uganda, International Obstetric Fistula Day 2020, 2020</p> |

Assumption 4.3: MHTF is an effective platform to host the Global Campaign to End Fistula, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone

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| <ul style="list-style-type: none"> ○ There is a gap in availability and access of some family planning methods in some health facilities contributing to unmet need of family planning and increased risk of fistula occurrence. ○ There are few skilled fistula surgeons, and this creates a backlog of fistula. ○ Late referrals from lower-level facilities contribute to the morbidity at CEmONC facilities including fistula occurrence. ● Immediate follow-up action items included: printing and dissemination of data tools, on-site validation of data with DHIS, funding to improve transport, upgrading function of theatres in HCIV facilities to perform C-sections, increased support for family planning, additional training for skilled fistula surgeons (2 per every regional hospital), regular (quarterly) follow-up of facilities that delay referrals. | |
| <ul style="list-style-type: none"> ● 2019 marked the 16th Anniversary year landmark of the Campaign to End Fistula, the purpose of which is to “enhance visibility; generate new ideas/evidence on obstetric fistula and also strengthen partnerships in the fight to move the fistula agenda.” (p. 2) The theme was “Fistula is a human rights violation – end it now.” The MoH in collaboration with UNFPA and other partners and stakeholders organized to observe the day in Rukungiri District, Western Region which has one of the highest numbers of fistula cases as per the Uganda DHS surveys from 2006, 2011 and 2016. Two private not-for-profit facilities, i.e., Kisiizi and Bwidi mission hospitals, and Kabale Regional Referral Hospital have the capacity to carry out fistula camps. ● One of the activity highlights was the State Minister for Health condemned child marriage and teenage pregnancies in the districts and called for new laws to address child and forced marriage and make parents and community leadership accountable. ● Recommendations and immediate follow-up actions included the need to expand the repairs to general hospitals so as to bring the services closer to the consumers and the need for routine fistula repair services (even though emergency services crowd out routine surgeries). | <p>UNFPA Uganda, International Obstetric Fistula Day 2019, 2019</p> |
| <ul style="list-style-type: none"> ● The International Day to end Obstetric Fistula celebrations were held on 23 May in Kibuku district under the theme: “End Fistula Now: Reach Every One.” A week prior to the event, UNFPA and partners supported a fistula camp which saw 25 women from the region get free repairs at Mbale Regional Referral Hospital. A fistula march organised by WAWI consisting of survivors, students, local NGOs and CSOs, politicians and other stakeholders was part of the occasion in Kibuku town. | <p>UNFPA Uganda, UNFPA-MoH Annual Workplan Progress Report, 2018</p> |
| <p>Zambia</p> | |
| <p>Increasing awareness through Campaign to End Fistula</p> <ul style="list-style-type: none"> ● UNFPA Zambia developed a concept note for the Zambia News and Information Service (ZANIS) to increase awareness of fistula in Zambia. It highlighted the efforts of UNFPA and its partners to launch the Campaign to End Obstetric Fistula, now present in 50 countries and with 80 organizations collaborating at global level and hundreds more at national and local levels. ● Key points made in the note include: <ul style="list-style-type: none"> ○ Zambia joined the campaign in 2003, but much remains to be done given the lack of access to EmONC services and referrals. ○ Only 5 out of 38 hospitals repair fistula on a routine basis for fewer than 200 patients a year. | <p>UNFPA, Zambia. Concept Note: Management of Obstetric Fistula in Zambia (prepared for Zambia news and Information Services.) Undated.</p> |

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| <p>Assumption 4.3: MHTF is an effective platform to host the <u>Global Campaign to End Fistula, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone</u></p> | |
| <ul style="list-style-type: none"> ○ UNFPA and partners have supported treatment of 1,786 fistula survivors since 2005 at static facilities and fistula camps. This year (unknown), five camps were conducted at St Fancis Mission Hospital, Chilonga Mission Hospital, Mansa General Hospital, St, Paul Mission Hospital, and Solwezi General Hospital for a total 163 fistula survivors. In addition, 38 fistula survivors have been repaired via routine services at Monze Mission Hospital and UTH. ● Data is not easily available, but it is estimated that there are “tens of thousands of fistula cases in Zambia and that over 2,000 fistula patients await surgery every year.” (p.1) | |
| <p>International Day to End Obstetric Fistula</p> <ul style="list-style-type: none"> ● UNFPA Zambia supported the national commemoration of the International Day to Eliminate Obstetric Fistula and Safe Motherhood week in May 2019 to continue raising community awareness on the need for skilled deliveries to prevent obstetric fistula as well as for the available of fistula repair services in Luapula Province. In collaboration with Fistula Foundation who supplemented efforts through support for community awareness programmes, training of SMAGs, and tracking fistula survivors, 30 fistula survivors were tracked and 29 had repair surgery. | <p>UNFPA Zambia. MHTF2019 End of Year Annual Report. Undated.</p> |
| <ul style="list-style-type: none"> ● The theme of the 2019 National Commemoration of Safe Motherhood Week held in May was “Universal Access to Sexual and Reproductive Health Services: Leaving No One Behind.” It was held in Mkushi District in Central Province at the Chibefwe Urban Clinic. The First Lady was a guest of honor and gave a speech on Donations of baby packs (from WHO) and dignity packs (from UNFPA) were distributed. ● Safe Motherhood Week was an opportunity to coordinate a range of activities, including: <ul style="list-style-type: none"> ○ Social mobilization through radio programmes on GBV, cervical and breast cancer, pregnancy complications and fistula, nutrition, adolescent SRH, voluntary male circumcision, newborn baby care and obstetric fistula. The radio programmes reached over 200,000 people. ○ Anti-GBV sensitization meetings in areas with high incidence of GBV according to police reports (Musofu, Itala and Kangili). These were led by two Victim Support Unit police officers and one health worker and covered such topics as causes and effects of GBV, the role of the community, early child marriage, children’s rights. A total of 2,1451 persons attended these sessions. ○ Training for Chiefs in safe motherhood. Five chiefs and 15 Chilolos and head men were also trained. ○ Training of SMAGs (n=20) on the importance of early antenatal booking and facility delivery. ○ Health service delivery, including family planning, breast and cervical cancer screening, HIV testing and a blood drive. ● Surgical operations done during Safe Motherhood Week: obstetric fistula repairs (n=13), tugal ligations from Mkushi and Luano Districts at the Mkushi District Hospital. | <p>Chisi, Mercy Mulwanda. Activity Report: National Safe Motherhood Week Commemoration, Chibefwe Urban Clinic, Mkushi District. 2019.</p> |
| <ul style="list-style-type: none"> ● UNFPA staff consider the International Days of Fistula during Safe Motherhood Week to be a good way to raise visibility of fistula. However, they note that there is not a good way to track the outcomes related to this goal and whether it is worth the investment. “What are the outcomes we want to see from these days? An increase in the national budget? A shift in attitudes? An increase in the number of fistula clients? Cost-effectiveness is hard to determine.” It is not seen as costing a lot of money; however, the level of effort is high and there is an expectation that we follow the global lead from headquarters. | <p>Interview, UNFPA Zambia staff, Lusaka, August 2021.</p> |

Assumption 4.3: MHTF is an effective platform to host the Global Campaign to End Fistula, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone

- “We would love to see increased activities in advocacy, including on special days such as International Day to Commemorate Fistula.” **UNFPA supports some advocacy activities through the media and through the organization itself. However, this year advocacy activities were reduced as a result of COVID-19, apart from a few programmes on TV and radio.** UNFPA has also supported advocacy activities in the three provinces: Luapula, North-Western and Western and their respective communities through the sensitization of people on fistula. This is tied to when there is a fistula treatment camp.
- **Advocacy is also done through the Safe Motherhood Technical Working Group**, which is chaired by the MoH and which UNFPA is part of. Fistula is one of the issues that are discussed during these meetings.

**Interview, MoH service provider.
Lusaka, Zambia. August 2021.**

Area of Investigation 5: Integrated SRHR

Evaluation Question 5: To what extent has the MHTF contributed to strengthened integration between maternal health and sexual and reproductive health (with a focus on family planning, post-partum family planning, post-abortion care and safe abortion care (where legal); cervical cancer prevention; PMTCT, and SGBV to achieve quality service delivery, to increase client satisfaction and to stimulate greater public demand for SRHR services?

- a) How and to what extent has UNFPA advocacy for strengthened integration between maternal health and SRHR resulted in adoption within various strategies and initiatives at global, regional, and national level?
- b) To what extent have UNFPA-supported models and approaches for linking MNH and SRHR been implemented at national level within health service delivery settings (supply) and behaviour change and communication efforts (demand)?
- c) To what extent has UNFPA supported integrated programming and synergies within MHTF (across the four core technical areas) and with other UNFPA technical areas (UNFPA Supplies, SRHR, Gender, Youth, etc.)?

| Evaluation criteria | <i>Relevance, effectiveness, efficiency, coordination</i> |
|---------------------|---|
| Rationale | In order to support women and adolescent girls across their lifespan, there needs to be in place a continuum of care from sexual and reproductive health through to pregnancy and the postnatal period and wellness across all stages. Women and newborn are at the highest risk of death and morbidity during labour, childbirth and in the first week after birth. The MHTF aims to support countries to address the “three delays” in accessing quality maternity care and improving the post-partum or post-abortion period. The MHTF supports countries to strengthen access to and the quality of antenatal care, with special attention to adolescent girls and youths. The antenatal care package includes essential sexual and reproductive health information and services, such as for the prevention of unsafe abortion, access to safe abortion (where legal) and the prevention of mother-to-child transmission of HIV. |

Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional and national strategies and plans

Indicators:

- MNH services integrated into PHC and UHC protocols, approaches, GFF investment cases and SDG3 global action plan process, where applicable
- Examples of MHTF leadership for ensuring global and regional attention to MNH-SRHR integration within global initiatives, (such the Global Strategy for Women’s Children’s and Adolescents’ Health, the ICPD 25 Nairobi business, and the SDG3 global action plan process)
- GFF investment cases (where applicable) include a full complement of SRHR and MNH services.
- Activities in countries linked to the Global Action Plan initiative
- National health sector strategies and plans incorporate linkages and integration of MNH and SRHR, including post-partum contraception, postabortion care, safe abortion care (where legal), cervical cancer prevention, prevention of mother to child transmission of HIV (PMTCT)
- Views of partners and stakeholders on the role of UNFPA leadership on progress toward integration with global, regional, and national strategies and plans.

| Observations | Sources of evidence |
|--------------|---------------------|
| Global | |

| | |
|--|---|
| Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional and national strategies and plans | |
| <ul style="list-style-type: none"> ● GFF was supposed to be for maternal health, UN agencies were supposed to be technical agents. The World Bank (WB) took it over and other agencies got marginalized. World Bank adopts a project approach, with poor to no participatory work, no cooperation with UNFPA COs, called at last minute to show that UNFPA was there. MoH struggles to be heard. No framework for maternal health (two years ago). Technical discussions are poor at country level or at HQ level. | Interview with MHTF Staff, New York, February 2021 |
| <ul style="list-style-type: none"> ● UHC is a focus for UNFPA – it is not a new thing because we have always talked about universal access – but in the framework of UHC it is a new concept. UNFPA has been very active in advocating for the SRHR to be a part of the UHC; at the MHTF level, we are looking at where is the place of MHTF in UHC and trying to identify key messages on that. It is very important to UHC that we work in the way we do, working with country governments to integrate MCH, etc. ● “We have not looked at specific packages in UHC. We could do more if we have more funding – but UNFPA is really “a baby” and there is not much internal technical capacity on social protection and health insurance. If I answer honestly, we use it more as a frame to say that MH is important, it is part and partial of UHC – our EmONC networks are very much in line with UHC – we try to reach everyone in the best manner.” | Interview, UNFPA staff, New York, February 2021 |
| <ul style="list-style-type: none"> ● There is a need to guide COs about how to approach and talk about the issues and talk about the MHTF issues as linked and interrelated. Government has to lead though, and each country will have a different approach to knowledge and insight. | Interview, development partner (private foundation), August 2021 |
| <ul style="list-style-type: none"> ● The new business plan has a stronger integration agenda, but not so strong in terms of the indicators. Hard to measure. Has not been a clear picture in the team about what does success look like ● Know there was very different understanding of integration: SRHR and maternal health whereas others see a broader integration. Who should be doing the integration? What kind of integration and at what level? ● Progressive realisation in UHC in UNFPA – has not trickled down to colleagues in the team or in the country level ● Need a strong and united vision. Integration is diffuse – how to operationalise it is still needing support. No SRHR experts at UNFPA. Technical specialists but no people that have the full broad skillset on broad SRHR focus. Need the full agenda ● Between human rights branch and SRH branch (and thematic fund) on rights-based approach. Needs to be stronger. ● Paternalistic approach to “saving women” ● Working at the UN – need to know what a human rights approach is and how to apply it. Need skills and need to apply it. Need to invest in staff and skills and knowledge and understanding to help them navigate these things ● Local staff – good for local knowledge but also a challenge: stigmatisation but also own cultural baggage and perceptions as well. | Interview, Development partner (bilateral), July 2021 |
| Sudan | |
| <p>Advocacy and strategies for integration</p> <ul style="list-style-type: none"> ● “Integration is one solution to scarcity”. In response to the situation in which there is not enough of anything (staff, commodities, facilities etc), integration enables more to be done with less. Midwives, for example, do not just do maternal health. They also attend the needs of babies and children, for example, with vaccination. ● Integration is a core component of health systems strengthening and the EmONC network reinforces this approach and enables support to be focused on other services as well. | Interview, RH Team, UNFPA CO, Khartoum, 17 June 2021 |

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|---|---|
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| <p>Integration has a range of determinants</p> <ul style="list-style-type: none"> ● At the facility level, UNFPA adopts a health/medical/service-oriented approach with people. But they adopt a socio-political approach at the higher political level. FGM abandonment, for example, is a strategy for maternal health as is the policy on raising the age of marriage. So, there are sensitivities about implementing/enforcing the law that has raised the age of consent/marriage to 18. The UN agencies in Sudan work together and discuss a lot with the government. ● FGM abandonment is there and growing but not so much is happening with abandoning early marriage. Slow progress. “Not 100 per cent support though”. | <p>Interview, Partner to UNFPA Sudan, Khartoum</p> |
| Benin | |
| <p>Contexte</p> <ul style="list-style-type: none"> ● ANSSP (Agence Nationale de Soins de Santé Primaire) – nouvelle agence créée en 2019 et qui est le principal interlocuteur du MHTF – couvre toutes les thématiques de la santé primaire, y compris SMN et SSR ● Le gouvernement dispose d’un paquet de services minimum intégré (SR/PF/VBG/VIH) ● Dans les centres de santé, nous avons un paquet minimum d’activités qui intègre tout. Les centres intégrés sont nécessaires et l’intégration est comprise dans nos documents. ... Ce sont des problèmes complexes et nous devons avoir une vision holistique de la santé, qui inclut le dépistage. | <p>Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin</p> |
| <ul style="list-style-type: none"> ● As far as possible, the national policy is to take advantage of the opportunities of one service to render another. So, everyone is looking for opportunities for synergy in programmes. This is not the preserve of UNFPA. | <p>Interview with a national staff from a bilateral donor organisation, Benin, June 2021</p> |
| <ul style="list-style-type: none"> ● La vision globale sur laquelle reposent les nouveaux documents de santé communautaire est une vision beaucoup plus large qui ne cible pas, qui s’éloigne un peu des OMD 3 et 4 qu’on avait, qui sont focalisés sur des cibles spécifiques notamment la mère et l’enfant. Mais aujourd’hui la nouvelle politique de santé communautaire, comme d’ailleurs beaucoup d’autres documents comme le PSNIE qui a été élaboré au niveau du CNLS-TP, ce sont des documents de référence qui, globalement ont pris pour cible la population générale. Il s’agit du One Health qui ne priorise pas forcément certaines cibles et qui met en avant les épidémies et autres. Donc quand vous prenez ces documents de référence, vous ne voyez pas des protocoles qui focalisent sur la mère et l’enfant alors que quand nous parlons de mortalité au Bénin, les plus vulnérables c’est la femme et l’enfant. Donc ces documents, tel qu’on s’apprête à les mettre en œuvre, n’ont pas d’approche spécifique tels que les SONU pour focaliser l’attention sur des cibles spécifiques. Donc il faut attendre de voir comment ces cibles spécifiques seront prises en compte lors de la mise en œuvre, puisque ces documents viennent d’être adoptés. | <p>Entretien Donneur bilatérale, Juin 2021, Benin</p> |

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L'intégration est au cœur de la logique du MHTF : c'est le « how » du programme
 A Vision for maternal and neonatal health/ SDG 3.1

The complex block contains three images. On the left is a map of Benin titled 'Carte du Réseau SONU national (2018)' showing various health facilities. In the middle is a poster with icons for a woman, a baby, a hand, and a heart, with the UNICEF logo below it. On the right is a photograph of a group of smiling midwives in pink uniforms. Below each image is a label: 'Prioritization & costing/budgeting' (WHAT), 'Integration of SRHR' (HOW), and 'Midwives save lives' (WITH WHOM).

UNFPA CO, Maternal Health Thematic Trust Fund, A story from the field
 Haiti – Congo – Benin, powerpoint presentation, pas de date

Les acteurs gouvernementaux reconnaissent le besoin d'intégration

- **VBG, SSR et SMN ne peuvent pas aller l'un sans l'autre** : Une sage-femme doit pouvoir parler à une femme qui accouche de la contraception et le sujet doit être intégré dans l'enseignement. On a commencé à aborder le sujet de **la violence** lors de notre 1ere journée scientifique et nous souhaitons vulgariser ça au niveau des formations périphériques dans le cadre des enseignements SONU, **mais ce n'est franchement pas rentré dans les attitudes pour l'instant**
- **La SSR alimente conflit entre anciennes et nouvelles** car les nouvelles arrivent avec des nouvelles compétences : **Les anciennes ne connaissent pas la SSR** ; dans les grands centres, différentes sages-femmes s'occupent de différents sujets, mais dans les cliniques, chaque sage-femme fait tout. Toutes les sages-femmes ne sont pas capables de travailler avec les jeunes ; certaines n'ont pas de formation en VBG : Il existe un cours de 4h en 2eme et en 3eme : Certains protocoles existent, mais chaque centre décide. La fiche de monitoring ne comporte pas GBV pour l'instant.
- Le **programme Passerelle** [pour permettre aux anciennes de passer la licence] se concentre beaucoup sur la SSR

Ministère de la Santé, Benin, Mai 2021 – Ecole de sages-femmes

Uganda

- **The CP8 contributed to the UNFPA Global goal of the Strategic Plan, 2018-2021**, which was to “achieve universal access to SRH, realise reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population Dynamics. This was to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality”. The CP8 pursued four programme outcomes in the areas of SRH, AY, GEWE and PD. **The SRH component had three outputs namely:** (Output 1): national and District Local Governments (DLGs) have the capacity to deliver comprehensive high-quality maternal health services, including in humanitarian settings, (Output 2): national and district governments have the capacity to increase the demand for and the supply of modern contraceptives; and (Output 3): increased national capacity to deliver integrated SRH and HIV/AIDS

UNFPA Uganda, GOU/UNFPA 8th Country Programme Evaluation Report, 2020, p.13

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| <p>prevention programmes that are free of stigma and discrimination. The AY component had one output which was about increased national capacity to conduct evidence-based advocacy for incorporating adolescents and youth SRH needs in national laws, policies and programmes, including humanitarian settings. The GEWE component was expected to strengthen the capacity of national and DLGs for the protection and advancement of reproductive rights, and delivery of multi-sectoral GBV prevention and response services, including in humanitarian settings. The output of the PD component focused on increasing the capacity of national institutions and district governments for the production and use of disaggregated data on population, SRH and GBV for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings. (p. 13)</p> <ul style="list-style-type: none"> ● Integrated and holistic programming is required to address the high teenage pregnancy rate, standing at 25 per cent. UNFPA recognizes there are causal pathways between GBV, SRHR and HIV. For example, a significant proportion of pregnant women report experience of violence and were more likely to develop obstetric complications such as hypertension and premature rupture of membranes. It was also evident that child marriage and teenage pregnancy increased the risk of STIs, HIV/AIDS, cervical cancer, GBV, persistent and enduring inequalities, social stigma and isolation. | |
| <ul style="list-style-type: none"> ● MHTF works to support integration, equity and quality. The MoH plays a key role on integration and UNFPA supports the development of guidelines and now the investment case. | Interview, Bilateral donor, Kampala, Uganda, May 2021 |
| <ul style="list-style-type: none"> ● At the policy level: UNFPA Uganda has played a lead role in promoting and advancing the policy agenda for integrated SRHR, HIV and GBV. In the past, most success has been in advocating for integration of SRHR and GBV into existing HIV platforms and programmes. UNFPA played a lead role in advocating for and developing SRHR, HIV and GBV integration policy, but its approval has been pending for some time, due to the pending approval of the overall SRHR policy, which guides all other SRHR strategies and plans. UNFPA played a lead role in supporting the MoH to establish national coordinating platforms for integrated SRHR, HIV and GBV. ● At the operational level: UNFPA advocates (with government and their donors) for the delivery of “an integrated package of rights” which means they try to use all their funding streams (i.e. for FP, HIV, SRHR, GBV, MH) to ensure that the end-user receives an integrated package of SRHR/MNH services. If UNFPA does not have funding to cover for all those services, they encourage their IP to use other funding sources they may have, to complement the package. Example: Provision of integrated package of outreach services (i.e. health services taken to hard-to-reach communities at special outreach days). Some progress has also been made to support the MoH to develop indicators to track integrated service delivery at facility level, although seems limited. | Interview, UNFPA Uganda national staff, May 2021 |
| <ul style="list-style-type: none"> ● UNFPA advocates for integration from global level to country level; however, programming is not always focusing on integration, “so it has been a slow walk to understand where to put your next foot on firm ground.” In 2009/210, UNFPA supported MoH to apply the Global Integration Tool to generate some evidence for MoH and used the findings to support MoH to develop the first strategy (around 2012). This has made some small steps in getting partners, especially on HIV platforms, to integrate, even faster than the SRHR platforms. In 2016-2017, UNFPA supported the revised integration strategy, but unfortunately could not take it through the approval process. It was the same time that the MoH refused to sign off the | Interview, UNFPA Uganda national staff, May 2021 |

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overall SRHR policy guideline. The MoH did not approve a lot of other strategies, including the comprehensive condom programming strategy. **In 2019, there was a breakthrough as the MoH top management agreed that the SRHR policy guideline should provide for provision of SRHR services to adolescent, age 15 and above.** This applied to the other documents, including the integration strategy; it is now pending again at senior management. There is good political will, the current PS is supporting integration – but more from the UHC perspective – but UNFPA successfully advocated to use SRHR as entry point. The PS also approved the “SRHR, GBV, HIV Steering Committee” which was established in 2018. As far back as 2016, the MoH established a technical task team on this integration. It was supposed to be chaired by Director for Clinical Services, but it is now delegated to Assistant Commissioner SRHR, which should ideally bring on other sectors, like gender, CSOs etc. It is the team that UNFPA uses to review concepts for clearance before they are implemented. It is the same team that supports the Sida funded 2gether4 SRHR.

- **The sharpened plan (i.e. the new RMNCAH investment case) is currently in development** – there is a review process in the final stages. The integration assessment revealed that the biggest challenge is that there are many vertical programmes. There are challenges with integrated supply chain systems – the HIV and SRHR commodities still flow through vertical systems.
- UNFPA has worked on HMIS/DHIS2, “in 2016 we worked on HMIS indicators, to see **how we can track integration**. In 2019/2020, we managed to have **a few integration indicators on the DHIS2 platform** – we have managed to have some, not all, to assist us having integration indicators – e.g. in facility X, client Y received 2 services (but we still do not have possibility of saying that a client received more than 2 services). Some progress has been made.”
- UNFPA also participates on HRH platforms. “**HRH is the elephant in the house**. It makes it more complicated to advocate for a smaller piece – like SRHR, GBV, HIV integration. We have reviewed pre- and in-service tools for integration, and partially used the results differently, e.g. WHO is supporting curricula review for pre-service. We also made input into the HR strategy that is running. But since the problems are at macro level, getting to one piece, becomes a bit challenging. We are working on mentorship and supportive supervision – with a focus on integration – this is linked to HR platform. We developed an **“integration scorecard” which uses DHIS2** but also data from facilities (when not reporting in HMIS/DHIS2). At the (SRHR) conference (UNFPA organised a large multi-stakeholder conference focusing on SRHR, HIV and GBV integration in February 2021 – with Sida-funding), the outcomes of the tool were shared. UNFPA supports the in-charges and health workers to use the scorecard, go through gaps in skills sets, working with regional referral hospitals to do the skills training and mentorship on integration.”

Togo

- Le pays est dans la dynamique de la couverture santé universelle pour les soins maternelle. Le Bureau est en train de faire le plaidoyer pour une intégration de la PF dans le Paquet de soins gratuit retenu. Dans cette dynamique la Banque Mondiale apporte un cours financier à travers un projet de 5ans. Un travail en est en cours avec la BM pour l’intégration des SONU en bonne place dans les interventions à financer.
- Modèles de programmes d’intégration des services de SMI et SSR (offre de planning familial intègre dans les soins post-partum ou dans les soins post avortement, services d’avortement sans risque (là où il est légal), la PTME) ?
- Le programme UNFPA a

UNFPA staff, Togo, June 2021

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|--|-----------------------|---------------|----------------|-----------------|--------------------------|--|
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| été initiateur de l'intégration de la PF du postpartum à travers un partenariat avec JPIEGO. Un appui est donné constamment au renforcement des capacités | | | | | | |
| <ul style="list-style-type: none"> In terms of service delivery, integrated services including ultrasound machines in mobile clinics and innovative family planning strategies such as community-based distribution and open houses were identified. Local resource mobilization and the removal of bottlenecks for integrating comprehensive sexuality education into curricula to better prevent early pregnancy in schools. | | | | | | United Nations, Agenda for the second regular session 2018, 2018 |
| Zambia | | | | | | |
| Government of Zambia emphasizes integrated approach to RMNCAH&N | | | | | | |
| <ul style="list-style-type: none"> The RMNCAH&N roadmap has been developed to accelerate actions to help meet the targets of the National Health Strategic Plan 2017-2021, which calls for a focus on the provision of a continuum of care with particular emphasis placed on the strengthening of health systems and services using the primary health care approach. The road map also supports the achievement of the Sustainable Development Goals. It identifies key challenges with respect to achieving the targets set forth within, namely: <ul style="list-style-type: none"> Inequities in the distribution of services between urban and rural areas, Low ratio of skilled providers in relation to population Inadequate service delivery infrastructure Weaknesses in the RMNCAH&N supply chain Inadequate community involvement for RMNCAH&N activities Weak quality assurance systems. | | | | | | MoH, Zambia. Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition Roadmap, 2018-2021. 2019. |
| <ul style="list-style-type: none"> UNFPA supported the revision of the National Guidelines for SRHR, HIV and SGBV Service Integration developed in 2013 to take into account the SADC SRHR strategy. Further, a Training Manual for Service Providers in SRHR, HIV and SGBV service integration was developed as part of efforts to scale up quality integration of services. The manual will enable service providers understand the importance and implementation process of the SRHR/HIV/SGBV service integration guidelines at health facility and community service delivery points. With UNFPA support to MoH, a Comprehensive Package of Adolescent Health Services and Standards for health care providers was developed. This package is pivotal in standardizing the provision of quality adolescent friendly health services in the country. | | | | | | UNFPA Zambia. 2019 Annual Report. 2020 |
| Online survey | | | | | | |
| | Strongly Agree | Agree | Neither | Disagree | Strongly Disagree | DK/NA |
| Effective Advocacy for Strategic Integration | 43.28% | 46.77% | 6.47% | 0.50% | 0.00% | 2.99% |

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|---|--------|--------|--------|-------|-------|--------|
| Effective Advocacy for National UHC Strategy | 24.62% | 44.22% | 17.09% | 3.52% | 0.00% | 10.55% |
| Evidence-Based Programming to Integrate MNCH and SRHR | 38.69% | 44.72% | 9.55% | 1.51% | 0.50% | 5.03% |
| Coordination Across Technical Program Components | 38.38% | 45.45% | 11.62% | 2.02% | 0.00% | 2.53% |

| Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services | |
|--|--|
| <p>Indicators:</p> <ul style="list-style-type: none"> • National health authorities confirm adoption/adaptation of evidence-based models and approaches for integration of MNH and SRHR, including but not limited to post-partum family planning (PPFP), post-abortion care, safe abortion services (where legal), PMTCT • Operational guidelines for health services staff include protocols for integration of MNH and SRHR information, services and referrals • Reported results from UNFPA-supported programmatic interventions to pilot, adapt, or scale-up integration models and approaches (PPFP, post-abortion care, PMTCT, etc.) • Reported results from efforts to expand ANC care package for essential SRHR information and services for adolescent girls and youth • Reported experiences and views of selected national health authorities and implementing partners on progress and challenges related to integration of MNH and SRHR. | |
| Observations | Sources of evidence |
| Sudan | |
| <p>SRH-MNH integration in the Sudan health system</p> <ul style="list-style-type: none"> • “Every member of the health care work force is engaged in the provision family planning-related services in ... Sudan. Sudan is the only country [among the study countries] with a large number of trained midwives working in the public health care system. These midwives share all the responsibilities of providing SRH services, very few roles are exclusive to them. These include the vital roles of promotion of family planning, cross-cultural communication with beneficiaries, education of women and their families/supporter in self-care, and promotion of shared responsibility with women, their families, and communities, leaving most of the clinical or other psychosocial roles to be covered primarily by physicians and, to a lesser extent, the rest of the cadre. ...work force-related challenges encountered in the provision of SRH services, mainly related to lack of capacity-building opportunities and shortage of staff time, in addition to maldistribution of qualified staff between rural and urban regions and brain drain. Shortages...of midwives and nurses...low wages in the public sector.” | <p>Kabakian-Khasholian T, and Ali A, UNFPA Assessment of Sexual and Reproductive Health Integration in Selected Arab States, The Middle East and North Africa Health Policy Forum (MENA HPF) and UNFPA ASRO, Cairo, December 2017. p.32</p> |
| <ul style="list-style-type: none"> • UNFPA “has a good contribution to make” on integration of services. • UNFPA supported the development of the integrated EmONC training manual, which includes training for the delivery of both maternal and neonatal care services. | <p>Interview, RH Team, FMOH, Khartoum, Sudan, 1 June 2021</p> |

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| <ul style="list-style-type: none"> UNFPA advocated for and supported the development of comprehensive SRH services including delivery services that are available at same place and concurrent with MNH services include ANC, FP, vaccination, nutrition, etc. | |
| Service integration in Blue Nile State <ul style="list-style-type: none"> MNH and SRH services are “well integrated”. All women after delivery are counselled for family planning which is provided at a specialized centre inside the hospital. In addition, they receive guidance and information about lactation and breast feeding, its importance, and the best ways to do it and solve breast-feeding problems. Vaccination for pregnant women and newborn services are “well supplied”. Post-abortion care services are also provided. | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021 |
| <ul style="list-style-type: none"> The [cervical cancer] screening will be integrated into other SRH services, like family planning, ANC, PNC and also EmONC. Also, referral pathways for management of cervical cancer cases that need advanced interventions were identified Essential cervical cancer prevention and pre-cancerous management equipment and supplies were procured and will be deployed after the health facility assessment Procurement of some consumables was initiated this year and still under process. | UNFPA, Prevention of Uterine Cervical Cancer in East Sudan, 2019, UNFPA, Khartoum, Sudan |
| Coordination among UN partners could improve <ul style="list-style-type: none"> “UNFPA is taking the lead of GBV and playing good role doing this and coordinating activities although sometimes UNFPA does not involve WHO in many GBV related plans and actions. However, we are looking for better collaboration and complementarity in the future.” | Interview, UN Partner, Khartoum, 3 June 2021 |
| Benin | |
| Activités du MHTF <ul style="list-style-type: none"> Production d’une note conceptuelle sur le renforcement du système de santé maternelle et néonatale dans le département de l’Atlantique (Modèle SONU+); Elaboration d’un modèle de services intégrés de santé de la reproduction, y compris la santé sexuelle et reproductive des adolescent(e)s, les violences basées sur le genre, l’Etat civil, les données statistiques désagrégées Elaboration d’un plan de travail annuel (PTA) pour l’amélioration des services intégrés et enfin La disponibilité d’un état des lieux de la maternité de Sô Ava pour apprécier les besoins en réhabilitation et équipement La modélisation des services intégrés sera poursuivie dans au moins un département (Atlantique), mais avec une extension dans l’Atacora. L’intégration du système de données, y compris les aspects de logistique des intrants, sera une priorité maintenue pour un suivi en temps réel et géo référencé des données. | UNFPA, MHTF Activity Report 2020, Benin, 2020 |
| <ul style="list-style-type: none"> Toutes les formations sanitaires ont été formées aux SSRAJ et toute l’équipe est formée La formation est axée sur la polyvalence des SOPS (standard operating procedures) VBG et les cas de viols sont référés au médecin | Entretien, UNFPA Staff, Mai 2021, Benin |

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| Intégration de la thématique SSR dans la formation des sages-femmes <ul style="list-style-type: none"> ● Depuis 3 ans, on parle de SSR dans la formation, avec les appuis de ISRP, UNFPA, INFP, APEFE, Enabel (programme Equité), en 2eme et 3eme année Le programme Equité (financé par l'AFD) prévoit la mise en place d'un Master en SSR | Ministère de la Santé Staff, Mai 2021, Benin Dir ecole Parakou, Gov staff |
| MHTF et formation continue <ul style="list-style-type: none"> ● 30 gestionnaires de services de santé sont formés en tant que formateurs au cours de l'année sur le paquet de services minimum intégré (SR/PF/VBG/VIH) avec l'appui de l'UNFPA. | UNFPA Annual Report, 2018 |
| Impacts de la formation continue MHTF sur l'intégration de la SSRAJ <ul style="list-style-type: none"> ● Formations : FNUAP intervenait – UNFPA a organisé beaucoup de formations (moins de 3 ans). La formation sur la SSRAJ a changé ma manière de travailler au niveau de l'accueil et de l'écoute des jeunes ; il faut connaître leurs besoins, pour mieux répondre à leurs aspirations. J'ai aussi appris comment me comporter en cas de viol, l'analyse de la situation et la référence. ● Bonne pratique : Centre convivial pour jeunes placé à côté d'un centre SONU : Il faut que les centres soient adaptés aux jeunes. Dans la clinique ou je travaillais avant, il y a un centre convivial (avec des jeux de cartes/foots). On joue avec eux et c'est là qu'ils parlent. Le bâtiment est séparé mais discret. Il faut être disponible pour les recevoir et s'adapter à leurs horaires (travailler à midi et après l'école), ça demande du personnel... quand les jeunes sont bien informés, ils vulgarisent eux-mêmes les thèmes dans la population et grâce à eux, on avait augmenté le taux de prévalence de contraceptifs... c'était un avantage d'avoir la clinique SONU à côté | Entretien, sage-femme, Juin 2021, Benin |
| Rédaction d'un modèle de services intégrés, fondé sur une étude cas manquant de substance <ul style="list-style-type: none"> ● Cette étude a conduit une analyse du niveau d'intégration au niveau de la ZS et d'apprécier les services effectivement intégrés, ceux qui ne sont pas encore intégrés, de souligner les forces et faiblesses en matière d'intégration et de proposer un modèle d'amélioration de services intégrés. ● Faiblesses relevées : Planification Familiale n'est pas souvent demandée, les prestataires sont timides dans l'information, la sensibilisation et l'offre de cette intervention. Absence de détection des violences. Recommandations : L'approche d'identification systématique des besoins de la cliente en contraception et l'amélioration de l'environnement politique et socioculturel sur la santé sexuelle et reproductive favoriseraient les prestations de PF. La déclaration de naissances et la détection des traces de violences basées sur le genre doivent être mentionnées sur la carte maternelle. | UNFPA Bénin, Elaboration d'un modèle de services intégrés de Santé de la Reproduction (SR) y compris les violences basées sur le genre, les données statistiques désagrégées et l'état civil dans la zone sanitaire Abomey-Calavi/Sô-Ava, 2019 |
| Intégration de la thématique SSR dans la formation des sages-femmes Depuis 3 ans, on parle de SSR dans la formation, avec les appuis de ISRP, UNFPA, INFP, APEFE, Enabel (programme Equité), en 2eme et 3eme année Le programme Equité (financé par l'AFD) prévoit la mise en place d'un Master en SSR | Ministère de la Santé Staff, Mai 2021, Benin Dir ecole Parakou, Gov staff |
| Résultats rapportés par UNFPA 32% de formation sanitaire publics au niveaux secondaire et tertiaire suivi, offrent un ensemble essentiel d'informations et de services intégrés de SSR pour les adolescents et jeunes (PF/IST et VIH, SONUB/VBG). | UNFPA, 2019 Annual Report - Benin, 2020, UNFPA, New York, USA |
| UNFPA est bien placé et respecté dans le secteur de la SSRAJ | Entretien, doneur bilaterale, Juin 2021, Benin |

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| UNFPA est l'araignée au milieu de la toile – ils occupent une position centrale dans le secteur de l'éducation sur la santé sexuelle. Toutes ces notions de SSR sont liées à l'égalité des genres et le plaidoyer de la Représentante est très fort sur ce sujet. | |
| Défis sur la vision stratégique de l'intégration | |
| Le problème est tout ce qu'on met dans la SSR : La maternité ne peut pas régler tout ça. | Entretien, Département de la santé du district Mai 2021, Bénin |
| <p>Une stratégie d'intégration qui dépasse les capacités des SONUs</p> <ul style="list-style-type: none"> ● Le sujet de l'intégration de la SMN et de la DSSR est une constante – on veut intégrer-intégrer-intégrer et je me demande jusqu'où... on ne regarde pas vraiment comment l'utilisateur final exploite cette intégration. C'est logique sur le plan économique mais jusqu'où va t'on ? C'est naturel pour le planning familial, mais qu'en est-il pour les VBG ? peut-être, dans une certaine mesure (à régler avec police/justice/juge) mais la première personne à qui la femme devrait parler est dans les services sociaux – mais ont-ils les capacités de répondre ? ● Quant aux services adaptés aux jeunes et adolescents, il faut se rappeler que les SONUs mettent les prestataires en situation d'urgence et il faut aller vite... or travailler avec les jeunes, c'est tout l'inverse, il faut prendre le temps. Les services de PF pour adolescents doivent être organisés autrement. On doit les organiser à côté, mais pas dans la même unité... Ils ont besoin d'un centre avec une entrée et une sortie différente et d'autres activités pour justifier leur présence, un environnement spécial est à créer (avec par exemple des jeux/vidéos/apps). | Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin |
| On communique mal avec les patientes [sur les VBG] mal mais c'est fondamental ; quand une femme arrive pour une consultation, on lui demande les antécédents, mais à la fin, on ne dit pas à la femme ce qu'elle doit faire quand elle rentre chez elle ; on agit selon nos moyens et quand vous avez 40 patients qui attendent, on n'a pas le temps de faire grand-chose | Ministère de la Santé, Bénin, Mai 2021 |
| Uganda | |
| <p>Development partner perspectives</p> <ul style="list-style-type: none"> ● When UNFPA was asked to show what they are doing at the field level to ensure coordination among IPs, it seems that they organize separate meetings by technical partners rather than bring together the partners who are complementary, all contributing to a common goal. This seems to indicate that the field staff do not manage via an integration philosophy; it is an out-put based management process. A strong integration approach would track in how activities are managed. ● The implementation/operationalization of a comprehensive, integrated package of SRHR services may still pose a challenge in some sub-regions, depending on the capacity of UNFPA to coordinate multiple IPs, implementing different technical areas/components of the programme at the sub-national level. | Interview, bilateral donor, Kampala, Uganda, May 2021 |
| <ul style="list-style-type: none"> ● "We have made good progress with our integration approach – linking MNCH activities with family planning and GBV. It is a steady progress. That is the purpose of our field support unit at the CO level and our field presence through the 7 field offices. Hopefully it ensures a strong anchoring of UNFPA at the district level. The biggest advantage is the ability to implement this within humanitarian settings." | Interview, UNFPA Uganda national staff, May 2021 |

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| <p>Support for guidance on PFPF</p> <ul style="list-style-type: none"> ● The aim these “change packages” is to address the range of supply and demand barriers that affect uptake of PFPF services along the continuum of PFPF provision. These barriers require changes to happen at different levels of family planning service delivery. ● The change packages will aim to address the following areas of improvement: <ul style="list-style-type: none"> ○ Family Planning counselling and education ○ Availability of quality family planning services and provider skills ○ Integrating family planning information and services in immunization ○ Data management and reporting for decision making ○ Strengthening community linkages ● Availability of contraceptive methods | <p>Unknown, Draft Postpartum Family Planning Change Package, Undated</p> |
| <p>UNFPA support for adolescent SRHR</p> <ul style="list-style-type: none"> ● In order to prevent teenage pregnancies, child marriages and harmful practices, UNFPA is implementing a ‘Live your Dream’ Campaign targeting adolescents and young people basing on the fact that adolescent and young people have dreams and inspirations to act on and realize their dreams. A multi-channel approach is used to engage communities in dialogue to address factors that lead to exploitation of girls and young people and hence prevents them from attaining full potential. ‘Live your Dream’ campaign is premised on four pillars namely: live your dream by Letting Girls be Girls: addresses Gender Based Violence, access to Family Planning and prevention of teenage pregnancies; live your dream by Choosing Books before Babies: speaks to keeping girls in school, getting proper education about SRHR and avoiding teenage pregnancies and HIV; live your dream – With You(th): reflects UNFPA’s position as lead youth agency, unleashing young people’s potential, empowering for innovation and social change. ● With You(th) also showcases our work in humanitarian settings where we bring host communities and refugee populations together to build resilience by promoting SRHR; live your dream by bringing generations together (Generation for Generation - G4G), is about sharing the wisdom of the elderly with the energies of the youth, tapping on the insights of academia with the diversity of views of decision-makers in order to improve policies that affect Uganda's future. This signature campaign is meant to inspire action towards a better life for young people and women and promote the well-being of the entire family. Its objective is to inspire and support women and men, boys and girls, young and old to identify with UNFPA as the cutting-edge organization that addresses population issues in their entirety ● UNFPA is also strengthening the functionalization of ELA clubs (Empowerment and Livelihood for Adolescents) model which integrates healthcare, encompassing reproductive health for boys and girls with livelihoods and economic empowerment sessions and targets youth between the ages of 10- 22 years mainly out of school and very vulnerable young people. The ELA clubs serve as safe spaces for adolescent girls, with a particular focus on girls who have dropped out of school or might otherwise be at risk of early pregnancy. | <p>UNFPA Uganda, 2019 MHTF Annual Report Uganda, 2019</p> |

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| <ul style="list-style-type: none"> ● The focus is on preventing and responding to effects of teenage pregnancy, increased use of contraceptives and menstrual hygiene, reduction in GBV and sexually transmitted infections. This supports girls to gain knowledge and confidence, enabling them to live safer, healthier lives. The primary aim of this model is to empower youth in achieving greater social and economic empowerment by implementing targeted interventions at individual, family and community levels on four assets: education, social network, health and economic empowerment including life education skills, small scale business and entrepreneurship. ● This is made possible through a network of adolescent clubs led by trained adolescent leaders (Mentors). By implementing this model, girls and boys will be supported to access the various services: in education where life skills are developed; health where SRHR information, contraceptives and other services are provided, social asset building, and financial literacy. ● UNFPA is also working with MoH to scale up an innovation called GetIN application aimed at increasing access to maternal health services by pregnant adolescents through timely identification and systematic follow-up of the girls in their communities. | |
| <p>Service provider perspectives on integration</p> <ul style="list-style-type: none"> ● “Our outreaches are integrated; we normally plan and do a lot of things, like ANC, FP, immunization, HIV testing, EID Exposed Infant Diagnosis, TB detection/samples, and adolescent services. At the facility, services are also integrated. When they come to OPD, they are also advised on family planning – she comes sick, but maybe she also wants family planning – and the children are checked if they are due for immunization. Hepatitis B, TB etc. They are also screened and tested. We also screen for pregnancy in the OPD and ART clinic, and then referred if they are pregnant.” | <p>Interview, MoH service providers, Lawmo District, Uganda, May 2021</p> |
| <ul style="list-style-type: none"> ● “Effective integrated delivery of services was however hindered by capacity gaps and skills among service providers on integrated SRHR/HIV and GBV services delivery, health systems challenge specifically on supplies stock outs and attrition/transfer of staff, unavailability of services at referral points, and inadequate human resource. Also, existing capacity to deliver services did not match with the demand that was created for services. Furthermore, there was no clear guidelines on integrated delivery of rights. The stakeholders were grappling with figuring out what an integrated package of services entailed and how to effectively deliver it.” | <p>UNFPA Uganda, GOU/UNFPA 8th Country Programme Evaluation Report, 2020, p.27</p> |
| <ul style="list-style-type: none"> ● “I can clearly see UNFPA as a convening partner, bringing together several stakeholders from different institutions. It is impressive how they brought together all those stakeholders, commissioners, ministries for integrated SRHR, GBV and HIV. To get that commitment of government, to show up, and to make commitments; it was a good thing they did, and quite impressive and a key achievement. UNFPA has established itself as a key institution on SRHR, talking about adolescents, family planning, etc. When you talk about those topics, you immediately see a strength here. | <p>Interview, Bilateral donor, Kampala, Uganda, May 2021</p> |
| <ul style="list-style-type: none"> ● UNFPA tends to work in a vertical way, i.e., pushing for a family planning costed implementation plan, when the government wants an integrated CIP across the RMNCAH continuum of care. The FP-CIP should be part and parcel of an overall investment case, as a family planning strategic plan. | <p>Interview, Multilateral Partner, Kampala, Uganda, May 2021</p> |
| Bangladesh | |
| <ul style="list-style-type: none"> ● Through MHTF support, Bangladesh and Ethiopia made strides towards integrating fistula into disease surveillance and emergency public health management information systems, respectively. UNFPA supported Bangladesh in conducting | <p>The MHTF UNFPA, Annual Report 2019, 2020, p.33</p> |

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| workshops to extend and strengthen its online, mobile phone based SRHR surveillance system to include a fistula reporting mechanism . This will be managed by the Institute of Epidemiology, Disease Control and Research of the MoHFW, supported by UNFPA. | |
| <ul style="list-style-type: none"> UNFPA has undertaken a number of initiatives to bring together MNH and SRHR including adolescents programme, long-acting reversible contraception, menstrual regulation, menstrual regulation with medication, family planning, post-partum contraception, GBV. | Immediate Past President of OGSB, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> UNFPA encourages integration; thus, midwives work in MNH as well as SRHR. For example, VIA for detection of cervical cancer, GBV, PFP have been recently included in revised curriculum and are also practiced by midwives. A section of the midwives has also been trained on menstrual regulation, menstrual regulation with medication and post abortion care. | Project Director, Save the Children, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> In partnership with UNAIDS and UNICEF, UNFPA has been providing integrated sexual and reproductive health services targeting 760 female sex workers in two brothels. Functional working relationship and referral linkages have been developed with district health, family planning, administration, law enforcement and women affairs department at the local level to ensure necessary support and services for this marginalized group. | UNFPA, 2018 Annual Report - Bangladesh, 2019, p.14 |
| <ul style="list-style-type: none"> UNFPA has undertaken a number of initiatives to bring together MNH and on SRHR including adolescents programme, long-acting reversible contraception, menstrual regulation, menstrual regulation with medication, family planning, post-partum contraception and GBV. | Immediate Past President of OGSB, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> Engagement of the he Obstetrical and Gynaecological Society of Bangladesh (OGSB) to provide mentorship to health care providers on cervical cancer is a strategic decision to integrate screening of cervical cancer as part of midwifery led SRHR comprehensive service package. | UNFPA, 2019 Annual Report MHTF Bangladesh, 2020, p.10 |
| Togo | |
| <ul style="list-style-type: none"> Nous faisons la sensibilisation dans la communauté dans tous les domaines. Nous faisons la sensibilisation en CPN, accouchement en milieu hospitalier par un personnel qualifié, planification familiale. Nous faisons les sensibilisations à tout moment. Surtout à chaque consultation prénatale, nous faisons une causerie aux femmes enceintes qui se présentent à nous. Pour les sensibiliser nous choisissons un thème pour la causerie et cela se fait à chaque début de consultation prénatale, chaque jour (Sensibilisation dans la communauté sur différentes thématiques). En CPN par exemple, il y a la CPN recentrée. Au cours de ces visite, nous sensibilisons sur le paquet de services que les femmes doivent recevoir en CPN, la prévention du paludisme, l'utilisation de la moustiquaire imprégnée, la planification familiale, la préparation à l'accouchement, il y a beaucoup de chose (sensibilisation pendant les CPN sur différentes thématiques). Je vais me concentrer sur l'éducation sexuelle des adolescents. Comme vous le savez les adolescents ont un paquet de service qui est bien différent des personnes adultes. Nous faisons un effort pour les recevoir et les prendre en charge mais ce n'est pas encore ça parce que leur service doit être vraiment adapté mais nous n'avons pas de local spécifique, nous n'avons pas d'endroit pour recevoir les jeunes (Absence de local pour recevoir les adolescents spécifiquement). Pour la prise en charge du nouveau-né nous n'avons pas de pédiatrie ici. Lorsque la médecine à notre niveau ne peut pas les prendre en charge, les nouveaux nés sont référés au CHR. Il y a des efforts | Midwife, Government, June 2021, Togo |

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| à faire pour prendre en charge toute la population ; je pense qu'il y a beaucoup à faire. Nous n'avons pas un service d'hospitalisation ici ça aussi s'est un effort à faire pour que le travail soit vraiment un paquet complet (absence de pédiatrie et d'hospitalisation.). | |
| <ul style="list-style-type: none"> ● Nous offrons un paquet de services à la maison de la femme et l'UNFPA nous a offert son appui pour la prise en charge du cancer du col de l'utérus. Le premier appareil de biothérapie nous a été offert par un projet « Projet Prévenir » par le CARESP (Centre Africain de recherche en épidémiologie et en santé publique). Pour la continuité des services, l'UNFPA a offert un appareil de biothérapie. Appui en réactifs et tout. | National staff, Midwives Association, June 2021, Togo |
| Depuis 2018, l'UNFPA a contribué beaucoup pour le renforcement des compétences des sages –femmes Formation de 928 accoucheuses traditionnelles à la prise en charge des femmes vivant avec le VIH Renforcement des compétences des sages-femmes à l'amélioration de la qualité de l'accueil | National staff, Midwives Association, June 2021, Togo |
| <ul style="list-style-type: none"> ● Pour parler de l'intégration nous avons aussi les activités que nous faisons à l'endroit des jeunes. Il y a le ministère de la jeunesse aussi qui collabore avec nous et c'est toujours avec les fonds de l'UNFPA. Il y a un point focal jeunes et adolescents qui fait des activités en intégration avec la SR. Les sensibilisations, tout ce que nous faisons sur la SR, on le fait ensemble. Quand une femme vient par exemple, si nous prenons le dépistage du VIH, une femme peut venir en planification familiale mais on va lui proposer en même temps le test de dépistage. Tout est intégré. Les soins des enfants aussi. On le fait ensemble depuis quelque temps déjà. C'est sur cette base que nous évoluons. On ne fait plus les choses différemment. Mais les soins intégrés ne sont pas encore appliqués chez nous. Il y a des pilotes à Lomé. Mais pas dans notre district. Ce n'est pas encore arrivé dans notre district. J'en ai entendu parler. Il y a eu des formations à ce sujet. Certaines formations sanitaires le font mais nous nous faisons habituellement ce que nous continuons de faire (Intégration des services non fonctionnelle dans le district). | District Health Officer, Government, June 2021, Togo |
| Zambia | |
| <p>Non-MHTF funded project on integrated SRH and MNH services.</p> <ul style="list-style-type: none"> ● Under this project, UNFPA has contracted MSZ (Marie Stopes-Zambia) to conduct trainings in adolescent friendly SRH service delivery, trainings in safe abortion delivery, trainings in comprehensive and cost abortion care, including oral abortion family planning, and tubal ligation under local anaesthesia. Other activities include strengthening of the health system quantification for commodities, commodity management, data collection and data management and trying out some key innovations. ● “We are an implementing partner in this partnership. UNFPA funds us to carry out key activities set out in the broader pragmatic document to help meet their broader MNH targets. In areas where core focuses intersect, we are able to produce key activities and once approved by UNFPA, we are then responsible for the actual implementation.” ● One of the key components of the partnership is innovation. The idea being tried out is the use of video cards to help improve information dissemination among CBDs. You know that CBDs are a key component of both information and service in the communities, not only are they responsible for trying to create demand for services on contraceptives, they are also responsible for delivery of some of those services. | Interview, National NGO staff. Zambia. August |

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| <ul style="list-style-type: none"> ● “It’s very rare that a funding partner allows innovation because most projects are very quantity result-oriented. What is unique about this project is that we have been allowed to experiment with new innovations regardless of the results. They have allowed us to take a risk so that we see whether this can be the future of SRH in Zambia. I think that takes a lot of courage on the part of the donor, or on the part of our partnership with UNFPA.” | |
| <p>Activities on integration: Midwifery Curriculum, capacity building</p> <ul style="list-style-type: none"> ● “Through UNFPA technical and financial contribution to MoH, the midwifery curriculum was revised in order to be aligned to international standards and incorporate emerging issues such as GBV, adolescent health and people living with disabilities, aimed at improving the quality of midwifery training and provision of quality SRH services. ● In addition, Respectful Maternity Care Guidelines were adapted to foster quality of care during pregnancy and childbirth. Further, within the context of advancing equity and leaving no one behind, a disability inclusion module for pre-and in-service training of health care providers was developed, and selected IEC materials developed in Braille to facilitate provision of SRH information to persons with visual impairment. ● In addition, capacity of 345 health care workers to provide adolescent friendly integrated SRH/HIV/GBV services was enhanced. As result, about 85,726 young people accessed adolescent and youth friendly integrated SRH services in 161 public health facilities. This was augmented by trained peer educators and counsellors who established adolescent friendly spaces and undertook community outreach services such as condom distribution and provided referral services.” | <p>UNFPA Zambia. 2019 Annual Report. 2020, p.2</p> |
| <p>Integration as strategy to leverage resources/create linkages:</p> <ul style="list-style-type: none"> ● Integration has allowed the Zambia CO to leverage resources from many programmes – “enables us to stop thinking about clients are a programme (family planning, MNH, HIV). Promotes client-centred perspectives in service delivery.” ● UNFPA is very involved in PFP as well as PAC where one of the key elements emphasized is being able to provide counselling for women who come through both PAC and CAC. UNFPA just started a collaboration with Global Fund to look at ways to champion integration. “For example, when we look at maternal health component, one of the key areas is teenage pregnancy. When you look at HIV – the highest level of incidence is happening in youth (19-24). When you look at both sides of the coin, we have a common denominator being adversely affected. If we are to develop message and programmes in young adults. Age bands that access a lot of abortion care – dealing with the same team. Currently have funding from DFID, specifically family planning and ASRH. Some of the key activities – integration of family planning and CAC. Resources that come from UK and resources from Swedes (Together for SRHR) and also have a programme that is running through the RO – ACCESS Project (CAC). Key things that resonate in all these programmes is integration.” | <p>Interview, UNFPA Zambia national staff. August 2021</p> |
| <p>Challenge</p> <ul style="list-style-type: none"> ● Implementing integrated SRH service delivery is often through a “patchwork” of resources. It is a challenge to coordinate the funds and timing of resources. “We will use the MHTF to train a midwife who is going to work in the CAC room, and the ACCESS project will procure the MVA kits. You have trained the midwife, but you do not get the kits from ACCESS. Resource envelope is a challenge to coordinate all the inputs.” | <p>Interview, UNFPA Zambia national staff. August 2021</p> |

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| Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services | |
| <ul style="list-style-type: none"> ● “When we talk about integration, the way services are structured, there is integration.” We had instances where there was a supermarket model, women walk in that clinic should be able to get all the services. ANC, HIV screening, family planning. But the model does not work because of staff shortages. Facilities segment services – Monday is for family planning, Tuesday for Child health, etc. In principle it is there, MoH wants to see. But depends on locations.” | Interview, UNFPA Zambia national staff. August 2021 |
| <ul style="list-style-type: none"> ● MHTF does not fund PFP per se; however, we promote it. It is a very good entry point for the next MHTF programme. “If the MHTF can supplement with family planning would be very happy as it would be supporting the capacity of the same midwife. It is the midwife who does those things. Would be very helpful. Building capacity in the same midwife. Ensure that she can do all the things family planning, MPDSR, EmONC – part of an integrated approach.” | Interview, UNFPA Zambia staff. August 2021 |
| <p>Partner perspectives on UNFPA leadership on integration</p> <ul style="list-style-type: none"> ● UNFPA has done its homework and helped to define a package of support for a joint programme. “UNFPA makes sure donors understood – adolescent health and SRHR, issues of respected maternity care. They defined a package, if you want us to intervene (central and Western province, this is the package. UNICEF came with a complimentary package with child health. They were convincing and we see their influence. There was enough strategic thinking so that the donors listened and saw a logical approach to linking everything together to advance maternal health. Unfortunately, UK discontinued funding for this kind of comprehensive programming.” | Interview, multilateral organization national staff. August 2021. |
| Assumption 5.3: The MHTF was an effective programme to shape the overall strategic direction of UNFPA in relation to the integration of SRHR and MNH and has acted as a catalyst within UNFPA to build commitment to SRHR – MNH integration as a vital strategy | |
| Indicators: | |
| <ul style="list-style-type: none"> ● Evolution over time of coordination mechanisms within MHTF for ensuring linkages in programming and outcomes across the four technical areas, i.e., fistula, EmONC, midwifery and MPDSR ● Structure and operation of coordination mechanisms at global, regional, and country level within UNFPA for ensuring linkages between MHTF and other areas of work, i.e., SRHR/the Supplies Partnership, SGBV/ gender, adolescents, and youth etc. | |
| Observations | Sources of evidence |
| Global | |
| <ul style="list-style-type: none"> ● It is because maternal health is so closely linked to family planning – family planning is the main strategy to prevent maternal deaths. [...] – we need to focus on and stick to SRHR. Interrelation of MNH on one hand and SRHR on the other hand. ● What about the integration across the four components of the fund – and also more broadly with the whole organization, e.g. integration with Supplies, Policy Unit etc? The narrative for the programme is quite clear. It is a slightly old-fashioned programme, and the four components can easily become silos. But there are three “ties”: <ul style="list-style-type: none"> ○ SRHR integration ○ Improving quality of care ○ UHC - position maternal health within UHC | Interview with MHTF Staff, New York, February 2021 |

| Assumption 5.3: The MHTF was an effective programme to shape the overall strategic direction of UNFPA in relation to the integration of SRHR and MNH and has acted as a catalyst within UNFPA to build commitment to SRHR – MNH integration as a vital strategy | |
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| <ul style="list-style-type: none"> ● While detention is an issue in certain countries, it is not the main issue – the main issue is that women do not have access, the women have to bribe everyone to get access. The funds UNFPA has (e.g., Supplies fund, MHTF funds) gives more flexibility, more creativity ● There is some collaboration with Supplies but needs to be strengthened This is where MHTF has a job to do – to attract donors who want to support HSS – and more technical areas as MHTF ● We have excellent collaboration with youth team, also in the area of cervical cancer, mental health in general (perinatal mental health) – establish a strong link to adolescents. The best thing would be for us and the youth team to have a joint donor to push that youth and maternal health integration – because most of the maternal health target groups that we are dealing with ARE young mothers ● FGM is very important. Focusing on youth-maternal health integration/linkages would strengthen visibility/attract attention The collaboration across sections at UNFPA is very good, compared to others, is very good, maybe because it is a small agency ● The way UNFPA organizes itself at the moment seems to be working for the best interests of these large areas, e.g., Supplies, maternal health, youth, FGM – it seems like vertical programmes, meant to attract funding/donors who want to support specific areas. What are your thoughts? Most of the member states do not want to change UNFPA, and its focus on SRHR. But we could benefit from a separate SRHR team/group working across/crosscutting, but there should be a strong separate SRHR unit. I am surprised that family planning is not within the SRHR team ● The midwife is at the heart of the MHTF; if we do not do the other areas (that support midwives) it will not be as effective. The other areas provide the full picture to strengthen the system ● Post-abortion care (where legal) ● Top priority for MHTF – higher impact within UNFPA and promoting integration with SRHR. | |
| <ul style="list-style-type: none"> ● The EmONC team addresses pre-service training issues and gender issues (with the midwifery component) and we also to link to MPDSR – as the key to improving quality of care. Linked to fistula. Fistula is one indicator for QoC. ● Support to facilities is critical. This component is so important. When it is well-organized, at scale, the assumption is that we will reduce maternal mortality. <p>Question re-integration about PFP and PAC:</p> <ul style="list-style-type: none"> ● PAC – part of EmONC approach. We include abortion complications as a complication within maternal morbidity. Civil society – this is not the place for us to address abortion as it is a technical process. We do not make it a big topic in a technical meeting. This issue is tracked and addressed in EmONC facilities. ● For reproductive health, we track PFP and cervical cancer. Need to highlight the family planning component. We measure PFP and PAFP. UNFPA supplies does not track this information. The integration of care is an important question. We have been discussion this for a long time – how to do it is challenging. You have the roof, but you need the foundation. You need to staff and the equipment. A facility with just one nurse, you cannot integrate care or have quality. We really have a lack of quality in Africa in countries with high maternal mortality. What we observe in our monitoring, start with facility, then | <p>Interview with MHTF Staff, New York, February 2021</p> |

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| <p>Assumption 5.3: The MHTF was an effective programme to shape the overall strategic direction of UNFPA in relation to the integration of SRHR and MNH and has acted as a catalyst within UNFPA to build commitment to SRHR – MNH integration as a vital strategy</p> | |
| <p>competencies of staff. Cannot do a reasonable integration of care without these foundations. We need to organize the EmONC facilities first; once the foundation is OK, then can elaborate the other components.</p> <p>Relationship to the Supplies partnership and how you interact (8 per cent Supplies are maternal health commodities) at global level.</p> <ul style="list-style-type: none"> ● Informal and formal discussions with the team. We have an informal agreement re: Life-saving commodities for maternal health. We can request support if there is an issue somewhere/additional support. At country level, we co-finance staff with UNFPA supplies (not core staff). This one colleague, coordinates for both UNFPA Supplies and MHTF. ● Stakeholders (USAID, MHTF, UNICEF) coordinate on maternal health supplies. When we see there is a gap, we work with UNFPA supplies to increase support to the country. ● Also use the UNFPA Supplies survey to monitor stockouts. We also monitor life-saving drugs through our monitoring at facility level (the last mile). Our strategic agreement at global level, the CO coordination at country level. Coordination at country level works the best. ● Integration is resting on MWs. What is the role that MHTF is reserving for midwives? We just started to understand what it takes in terms of number of midwives for obstetric care. Need to elaborate further, more advanced study is needed. Issue with midwives, training, competencies, staffing in facilities, how to manage all the different requests. In each facility there is an integration of care everywhere of sorts, but it is not well managed. Quality is not there. How to do it. We propose a step-by-step approach. | |
| <p>Regional</p> | |
| <p>Interventions must be coherent, but internal coherence between activities is not sufficient. There is a need for more synergy between the four areas at operational level. Examples of insufficient integration:</p> <ul style="list-style-type: none"> ● You cannot talk about EmONC without talking about midwives ● Fistula cases reveal poor quality of care ● Which integration between fistula in EmONC domains? Fistula operations should be managed in BEmONC facilities (e.g., repairing small fistulas with a probe). Since the midwife is close to the community and represents "medicine", if the midwife refers, the patient will go to see a traditional practitioner because she will think that general medicine cannot treat her case. For this reason, it would be important to integrate the repair of small fistulas in BEmONC facilities. ● The celebration of midwifery day/week, which is supported by the MHTF in every country, is not linked to EmONC facilities. Why not taking advantage of this week to train midwives (for example on suction cups) and link this activity to the monitoring of EmONCs? | <p>Interview, UNFPA technical staff, 8 October 2021</p> |

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| <p>The issue of integration also refers to the issue of midwives and the need for more midwives.</p> <ul style="list-style-type: none"> • We have a problem of unwanted pregnancies, and we need to do more prevention at school. There should be more links between comprehensive sexuality education activities in schools and access to care, and the issue of school infirmaries should be addressed – this highlight again the need for more staff. • One cannot do prevention and emergency at the same time if one does not have enough staff – it prevents us from offering quality services and contributes to the non-functionality of networks. | Interview, UNFPA technical staff, 8 October 2021 |
| <ul style="list-style-type: none"> • Integration: The technical assistance at HQ-level can be improved on integration as the thematic focal points are holding vertical programmes, while at the regional level, it is only one person, so we do have to integrate. • In addition, the demands from the COs channelled to us are always integrated. | Interview, UNFPA technical staff, 21 October 2021 |
| <ul style="list-style-type: none"> • A people-centred approach at service delivery level is required and necessitates integration – or at least good referrals and bringing services closer to the people. The problem with integration is if you come only at service-delivery level, you bump into issues of salary/motivation/incentives. We need a systems strengthening approach for integration to work, and it is not that strong in the MHTF. | Interview, UNFPA technical staff, 21 October 2021 |
| Sudan | |
| <p>Taking steps towards integration within UNFPA itself</p> <ul style="list-style-type: none"> • “Within the UNFPA CO, a decision was taken in 2019 that all the sub-units related to SRH and MNH would be better linked up. Thus, all departments, including MNH, emergencies, RH supplies, MHTF and so on, are all coordinated together in a single unit within the CO and under clearer joint leadership. This was a physical as well as structural change. Three technical coordinators now work closely on a daily basis, and this helps manage gaps. For example, they use their access to RH Kits to ensure the gaps in Sudan are covered to some extent and this is facilitated by the new integrated structure in the CO.” | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| <p>EmONC Network as a driver of integration during COVID-19</p> <ul style="list-style-type: none"> • “The EmONC Network has served as a platform for a range of services including comprehensive RMNCAH. Integration has been essential to maximising the benefit of the network.” | Webinar presentation, FMOH, Khartoum, 17 June 2021 |
| <p>Shift integration to focus on comprehensive PHC</p> <ul style="list-style-type: none"> • There should be a greater focus by partners on integrating all basic services into PHC. RH is just one of multiple components and it is more productive to work towards a strong system that can delivery all seven basic types of services offered by the PHC Platform (vaccination, SRH, MNH, nutrition and child growth monitoring, etc.). Family health is part of PHC. UNFPA has adopted a focus on family health in a context of PHC where 85 per cent of services are delivered to women and children. Within this there are teams delivering RH. • The PHC approach also allows for the adoption of a psycho-social health care approach. A holistic approach enables UNFPA to take a wide-ranging perspective. MNH is affected/underpinned by a range of harmful practices including FGM and adolescent pregnancy, women’s empowerment and so on. | Interview, Leadership, UNFPA CO, Khartoum, 9 June 2021 |

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| <ul style="list-style-type: none"> ● UNFPA works across its programme to address FGM, for example, taking a wide view of its integration. So, the question of integrating SRH and MNH at the policy, planning and delivery levels misses the larger, more important goal of supporting partner countries to deliver a comprehensive, strong, quality primary health service. | |
| Benin | |
| Integration is materialized in the CO configuration Integration of SMN and SRHR is reflected in the configuration of the CO whose SRHR lead is the "integration pillar." | Interview, UNFPA Staff, Benin, May 2021 |
| The CO has a multidimensional and broad definition of integration The vision of the CO is not only to create specific services around the EmONC facilities, but to integrate the issues of young people and GBV in maternal health. Integration is a gradual process. | Interview, UNFPA CO staff management |
| Integration with GBV <ul style="list-style-type: none"> ● Integration between prevention and response to fistula, UNFPA is now working on prevention through family planning ● At the EmONC level: It is not relevant to develop medical training in addition to EmONC, so the EmONC network takes care of the medical complications linked to GBV ● Inclusion of GBV in the medical education of midwives (although this idea has not yet materialized) ● Integration of different donor support: The Canadian project has a component of GBV medical care and Takeda focuses on 33 EmONC facilities. EmONC: Asks Canadians to focus on health centres financed by the Takeda programme ● Integration at service level: <ul style="list-style-type: none"> ○ In terms of GBV, health centres are considered as the point of referral for others (police, social action) ○ Integration of psycho-social care in the health facility. As maternal deaths have a psychological impact on midwives, the psychologists who will take care of survivors of GBV will also take care of midwives in difficulty ○ The partnership with the police could also materialize at the level of the EmONC (where the police could have an office), so that the police go to the victim and not the other way around ● Integration at the level of geographic space, through the attention paid by the office not to duplicate. | Interview, UNFPA CO staff, Benin, May 2021 |
| The interconnection and synergy between different MHTF components exist conceptually but not in reality: Does the MPDSR reviews improve the functioning of EmONC facilities? This would imply the actions proposed by the reviews are 1) relevant and 2) put in place, which is not always the case. | DPT of health management |
| Uganda | |
| <ul style="list-style-type: none"> ● "Our comparative advantage is integration. When you strengthen one cluster, you strengthen the other, and hence, you strengthen the whole system. Linking MNH with SRH and GBV is the way to go." ● "UNFPA is a small contributor to MNH; therefore, you have to integrate, integrate, integrate." | Interview, UNFPA Uganda national staff, May 2021 |
| Zambia | |
| <ul style="list-style-type: none"> ● The CO wanted to introduce the First Time Young Mothers Model for preventing teenage pregnancy; however, the MoH was not keen at that time to have a standalone programme. It felt that young mothers were adequately taken care of by existing programmes. | Interview, UNFPA Zambia staff. August 2021. |

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- UNFPA Zambia used to receive UNFPA Supplies funds for supporting family planning-specific activities, training, and commodities. The same midwives supported by MHTF supported family planning trainings, as midwives at health centres are conducting ANC, deliveries, and FP. “Integration is a transformational goal for UNFPA. **Prevention of maternal deaths comes in with the use of family planning. We integrate family planning in maternal health component. Used to have funds as but it is not seen as a one stream. We do not use the MHTF funds for family planning, but the funds are given to the provider/who does it all.**”

Interview, UNFPA Zambia staff. August 2021.

Area of Investigation 6: Equitable and accountable access

Evaluation Question 6: To what extent has the MHTF contributed to strengthening the availability and quality of health service delivery and health information system to meet the diverse and differentiated needs of the women, newborns, and adolescent girls including in the lowest wealth quintiles, living in hard-to-reach areas, facing discrimination (based on identity, ethnicity, and/or faith) and/or living with disabilities?

Sub-questions:

- To what extent has UNFPA been effective in promoting and supporting national strategies and programmes, which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged?**
- To what extent have national governments responded positively to UNFPA advocacy and technical support by allocating resources, altering policies, and implementing programmes that strengthen the supply and demand sides of care, ensure equitable and accountable access to quality MNH and SRHR services and that meet the needs of and empower women and adolescent girls?**
- Have UNFPA-supported programmes have been effective in increasing the availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged?**

| Evaluation criteria | Relevance, effectiveness, sustainability |
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| Rationale | Globally, maternal mortality is the second largest cause of deaths among adolescent girls aged 15 to 19. Of all births globally each year, around 16 million (11 percent) are among girls in this age range; about 2 million are among girls under the age of 15. ⁵ Stigma, discrimination, judgmental treatment, lack of confidentiality, and inability to physically access services are important barriers to care for adolescent girls. The MHTF supports countries to improve access among adolescent girls to broader sexual and reproductive health services. Further, poor women in rural and urban areas and minority women have less access to quality maternal health care than wealthier women in urban areas. The MHTF supports their equitable access to MNH care and broader SRHR. |

⁵ UNFPA (2017). Maternal and Newborn Health Thematic Fund – phase III Business Plan, p.18

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| Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged | |
| Indicators: | |
| <ul style="list-style-type: none"> ● National strategies and plans support programmes and approaches that promote, assess, and address the differentiated needs of women, newborns, and adolescent girls, including the most vulnerable and disadvantaged ● National official statements regarding the protection of the rights of women and girls and “leaving no one behind”. | |
| Observations | Sources of evidence |
| Global | |
| <ul style="list-style-type: none"> ● In Phase III, the MHTF will: <ul style="list-style-type: none"> ○ Be guided by the core principles of equity in access, quality of care and accountability, and by human rights and gender equality. ○ Address rising inequities in access to sexual and reproductive health information and services. This will require a new way of doing business to increase the focus on reaching those furthest behind, including women, adolescent girls and newborns in the two lowest wealth quintiles, living in hard-to-reach areas, facing discrimination based on their identity, ethnicity and faith, and living with disabilities. (p.15) ● As part of this expanded scope in Phase III, UNFPA will: <ul style="list-style-type: none"> ○ Strengthen both the supply and demand side of care, empowering women, and adolescent girls to exercise their sexual and reproductive rights ○ Focus on the most vulnerable and disadvantaged – particularly adolescent girls, and women and adolescent girls in the lowest wealth quintiles, in hard-to-reach areas, facing discrimination based on their identity, ethnicity, race, residential and legal status, and living with disabilities (p.19) | UNFPA, MHTF Business Plan Phase III 2018-2021, 2018 |
| <ul style="list-style-type: none"> ● Equity in access implies that access to health care should be within reach of all, regardless of race, gender, ethnicity, disability, ability to pay, culture, geographic location, religion, political belief, or socioeconomic condition. Yet striking disparities in health still exist within and between populations. Inequities in access to care persist and tend to affect the most vulnerable people, such as the poorest or those with the most complex health-care needs. Women and girls have been disproportionately affected by the COVID-19 pandemic and its consequences given gaps in essential services and complex intersections among the determinants of health. (p.35) ● Ending fistula by 2030 also requires a vertical approach (such as continued and strategic UNFPA leadership of the global Campaign to End Fistula) and a horizontal one (such as integrating fistula into broader programmes on gender, human rights, disabilities, quality of care and SRHR, including adolescent sexual and reproductive health). (p.44) | UNFPA, MHTF 2020 Annual Report, 2021 |
| Regional | |
| <ul style="list-style-type: none"> ● No observations | |
| Bangladesh | |

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| Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged | |
| <ul style="list-style-type: none"> UNFPA firmly believes in Leaving No One Behind. It prioritises marginalized groups for its interventions including people in lowest wealth quintile, ethnic minorities (e.g., Saontals), disabled, other marginalized and vulnerable populations like tea garden workers, people living in climatically vulnerable (e.g., coastal) areas, hard to reach areas (e.g., hilly terrain). | Health System Specialist, UNFPA, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> UNFPA believes in equity, as demonstrated by setting up of midwifery services in union level facilities among the host community of Cox's Bazar district, which houses the Rohingya camps. | Project Director, Save the Children, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> The [COVID-19] pandemic will compound existing gender inequalities, and increase risks of GBV, the protection and promotion of the rights of women and girls should be prioritized. | UNFPA, Coronavirus Disease (COVID-19) Preparedness and Response, 2020, p.8 |
| <ul style="list-style-type: none"> UNFPA is ensuring care for marginalized and vulnerable groups across the country. This has included establishing maternity waiting homes, as well as water transport to and from facilities in remote hilly areas. Tea garden communities have been supported through training community health workers on maternal health counselling and supporting courtyard meetings. Midwives were placed in selected government facilities near tea garden communities and paramedics in tea gardens were provided skills training in quality MNH services. As a result, the number of marginalized women receiving services has increased. | UNFPA, 2018 Annual Report - Bangladesh, 2019, p.2 |
| <ul style="list-style-type: none"> The IsDB and UNFPA/ Campaign to End Fistula on 13 March 2018 co-hosted a panel discussion entitled "Preventing the Preventable: Reaching Rural Women and Girls through Obstetric Fistula Initiatives" - Improving rural women's access to maternal health services contributes to significantly protect them from being susceptible to preventable maternal morbidities. The panel focused on innovative approaches through obstetric fistula initiatives being used by partners to reach rural women and girls, while raising awareness on high potential OF eradication efforts, exploring evidence, experiences (from Bangladesh and Afghanistan), opportunities and challenges for scaling up OF efforts and getting OF related prevention and comprehensive treatment services to rural women. The importance of partnerships and coordination were reiterated as critical in improving the effectiveness in advancing OF eradication efforts. | UNFPA, Campaign to End Fistula Newsletter - April 2018, 2018, p.3 |
| Benin | |
| <ul style="list-style-type: none"> Quel est le rôle du MHTF pour promouvoir l'équité dans l'accès aux soins ? Ce n'est pas une priorité du MHTF au Bénin. Mais nous avons fait du plaidoyer pour demander que l'accouchement soit dans l'ARCH [système de couverture santé universelle] | Entretien, UNFPA bureau pays, Bénin, Mai 2021 |
| <ul style="list-style-type: none"> Quelles mesures sont en place pour favoriser l'équité dans l'accès aux soins de SMN ? Les tarifs d'accouchement sont suffisamment bas | Entretien, District Ministère de la Santé, Bénin, Mai 2021 |
| <ul style="list-style-type: none"> Les gens pas en mesure de payer immédiatement viennent payer plus tard. Souvent, on implique les chefs du quartier et on s'entend entre nous Les soins maternels ne sont pas gratuits – l'acte d'accouchement coûte 1000 FCFA, auquel s'ajoute le kit (matériel nécessaire) qui coûte 9000 FCFA (maximum 12 000) | Entretien, Directeur de clinique, Bénin, Mai 2021, |
| <ul style="list-style-type: none"> La solution pour les indigents est la Couverture sociale/couverture universelle, qui prévoit que « que tu sois pauvre ou riche, ton kit d'urgence te sera donné, car tout décès doit être rapporté/audité ». Ceci réduira le déficit propre de l'hôpital | Entretien, Centre de Santé, Bénin, Mai 2021 |

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| Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged | |
| <ul style="list-style-type: none"> ● Les frais de grossesse sont inclus dans ARCH ; la césarienne est gratuite. Le Ministère de la Santé a fait du plaidoyer auprès du Ministère des Affaires Sociales dans ce sens. | Entretien, Ministère de la Santé, Benin, Mai 2021 |
| <ul style="list-style-type: none"> ● Toutes les dernières semaines du mois nous organisons une campagne gratuite de PF. Ainsi, ceux qui n'ont pas les moyens peuvent venir bénéficier gratuitement de la consultation et des produits. Pour les autres services, nous mettons celles qui ne peuvent pas payer dans le groupe des indigents [dont les soins sont payés par le fonds pour les indigents]. Ça coûte cher mais la Zone Sanitaire nous aide. Je pense que c'est une politique nationale. | Entretien sage-femme, Centre de santé, Mai 2021, Benin |
| <ul style="list-style-type: none"> ● L'hôpital dispose de moindres ressources en ce moment à cause de la baisse d'activités liée au Covid-19, les charges salariales, les intrants. Nous avons des difficultés financières en Avril-Mai-Juin à cause de l'augmentation du nombre de gens démunis, nous utilisons donc nos fonds propres. Par exemple, au 1er trimestre 2020 = 5 millions FCFA étaient alloués à la prise en charge des indigents ; mais cette année 2021, c'était 10 millions. Nous attendons que le gouvernement donne plus. Nous sommes obligés de libérer les gens plus tôt pour éviter les charges. | Entretien, Directeur d'hôpital, Mai 2021, Benin |
| <ul style="list-style-type: none"> ● On réfère les indigents dans les hôpitaux car il existe un service social ou des centres sociaux – nous ne faisons pas de prise en charge ici à la clinique ● Projet ARCH va permettre la prise en charge des pauvres extrêmes par l'Etat ; les services de maternité font partie de ARCH – mais si une personne n'a pas sa carte, on ne peut pas la prendre en charge sans payer | Entretien, sage-femme, Juin 2021, Benin |
| Sudan | |
| <p>Delivering services to marginalized groups</p> <ul style="list-style-type: none"> ● I participated in a field visit to Kassala and sat in on very good discussions held with UNFPA and the health authorities at the state level. UNFPA clearly contributed and helped to build capacity and resources. But there is a high turnover at the state ministry and in the hospitals which is a big problem. They have to keep stopping and starting. I can say that when I am sitting with them in the field, they tried to integrate a full package of SRHR. They really do that but in Sudan, they do not have the full scope to do that because of legal and cultural issues. ● UNFPA “has to be very sensitive all the time”. There are rights that are not granted fully to women and girls. All the time one needs to think “how far can I push in this environment, with these women, in this setting”. For example – UNFPA is the only organization to support prostitutes/sex workers with health care. Also, the way to discuss LGBT rights requires sensitivity and care. Women working on the streets with condoms and health care. UNFPA takes a medical view, a system's view and “that sees them through” in the sense that this approach enables UNFPA to raise difficult issues in a wide range of contexts. | Interview, Partner to UNFPA Sudan, Khartoum, 10 June 2021 |
| <p>UNFPA juggles a range of exogenous challenges and events</p> <ul style="list-style-type: none"> ● Accessibility – conflicts and civil unrest in certain areas had its impact on programme implementation and achievement of expected results ● Economic – unstable exchange rate, increased market prices and shortage of fuel were major constraining factors for timely implementation. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| Early engagement delivers better results for the disadvantaged | UNFPA and GoS, 2020 Annual Progress Report - 7th Country |

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| Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged | | | |
| <ul style="list-style-type: none"> Early engagement in the response to different types of emergencies including floods, haemorrhagic fever, local conflicts, and influx of Ethiopian refugees helps in addressing the needs of women of reproductive age and facilitate their access to services. | | | Program Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| Togo | | | |
| <ul style="list-style-type: none"> Les interventions de l'UNFPA sont toujours alignées sur les priorités nationales. Dans le domaine de la santé, c'est le plan national de développement sanitaire (PNDS 2018-2022) qui est le document de référence. Dans le cadre du PNDS en cours d'exécution, l'UNFPA et l'OMS ont développé conjointement une stratégie focalisée sur la santé de la mère, du nouveau-né, de l'enfant et de l'adolescent. Ce sont ces deux documents qui servent de référentiel pour la programmation des interventions. Comme cela se fait habituellement, ce n'est pas une programmation UNFPA mais UNFPA travaille avec le Ministère de la santé à identifier les actions prioritaires et sur la base de ressources disponibles, l'UNFPA et le Ministère s'accordent sur les actions qui doivent être implémentées dans les cinq ans. Donc voilà ce qui se passe. L'UNFPA est parfaitement aligné sur les priorités du gouvernement. | | | UNICEF staff, UNICEF, June 2021, Togo |
| <ul style="list-style-type: none"> In 2018, with MHTF support, Guinea, Madagascar, Sudan, Senegal and Togo successfully defined their respective national networks of EmONC health facilities using GIS/AccessMod. They prepared for EmONC programme implementation and monitoring at a national scale. Madagascar started a similar approach, while in the Republic of the Congo, the MHTF support was used to develop a strategic partnership between UNFPA and Philips to help two rural districts improve access to maternal health and neonatal care for the Bantou and indigenous populations. This project will be further refined and extended at national scale during Phase III of the MHTF. | | | The MHTF UNFPA, Annual Report 2018, 2019 |
| Online survey | | | |
| | Strongly Agree | Agree | Neither |
| National Strategies Addressing LNOB and Reaching Vulnerable | 46.23% | 41.21% | 9.05% |
| Tech Support Contributed to Increased Expenditures for SRHR and MNCH | 26.63% | 50.75% | 12.56% |
| Uganda | | | |
| <ul style="list-style-type: none"> The International Day to end Obstetric Fistula celebrations were held on 23 May in Kibuku district under the theme: "End Fistula Now: Reach Every One." A week prior to the event, UNFPA and partners supported a fistula camp which saw 25 women from the region get free repairs at Mbale Regional Referral Hospital. A fistula march organised by WAWI consisting of survivors, students, local NGOs and CSOs, politicians and other stakeholders was part of the occasion in Kibuku town. | | | UNFPA Uganda, UNFPA-MoH Annual Workplan Progress Report, 2018 |
| Focus on underserved areas: | | | UNFPA Uganda. 2018 MHTF Annual Report. 2018 |
| <ul style="list-style-type: none"> UNFPA has continued to support sponsorship of bonded pre-service certificate midwifery students in the underserved target districts who upon qualifying work in their respective districts for at least 2 years. In addition, UNFPA has supported payment | | | |

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| of salaries for 16 midwives who deployed in selected humanitarian districts. A total of 584 midwives have been trained in GBV and Adolescent Health so as to be able integrate these areas into midwifery services. | |
| Zambia | |
| Advocacy for fistula geared to increasing political and financial commitment <ul style="list-style-type: none"> “Obstetric fistula is a form of gender-based human rights violation. It is a manifestation of deep socio-economic inequalities and inadequate reproductive health systems. Despite its reality and debilitation, obstetric fistula has remained a “hidden” condition, mainly because it affects some of the most marginalized members of the population. Therefore, it has limited visibility in decision-making processes at all levels of the system.” | Kasunda, G. Obstetric Fistula in Zambia. Undated, p.3 |
| IDM supports messages about LNOB <ul style="list-style-type: none"> The theme of the 2019 National Commemoration of Safe Motherhood Week held in May was “Universal Access to Sexual and Reproductive Health Services: Leaving No One Behind.” | Chisi, Mercy Mulwanda. Activity Report: National Safe Motherhood Week Commemoration, Chibefwe Urban Clinic, Mkushi District. 2019 |
| Focus on marginalized populations <ul style="list-style-type: none"> One of the unique things that I have noticed with UNFPA is that they actually really focus on PHC, when you look for example at the family planning services that they support. They also go into communities and look at some of the marginalized populations and these are patients for example who have fistula. | Interview, MoH service provider. Lusaka, Zambia. August 2021 |
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| Indicators: | |
| <ul style="list-style-type: none"> Changes over time in national strategies and plans that reflect increased attention to the differentiated needs of women, newborns and adolescents, including in the four technical MHTF focal areas Shifts and increases in financial allocations and expenditures to address needs of women, newborns and adolescents, including the vulnerable and disadvantaged Use of disaggregated data by health information systems to track equity in access to MNH and SRHR services, in particular EmONC and fistula care Views of national, district and community stakeholders regarding equitable access to MNH and SRHR services for women, newborns and adolescent girls, including the most vulnerable and disadvantaged Examples and results from UNFPA-supported programmes to strengthen supply and demand sides of MNH and SRHR care and empower women and adolescent girls. | |
| Observations | Sources of evidence |
| Global | |

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| <ul style="list-style-type: none"> ● Countries that piloted interventions supporting “first-time young mothers” over the last two years – one of the MHTF workstreams for Phase II – will be assisted to evaluate and document the results and encouraged to scale up best practices. This process will promote South-South collaboration, such as by sharing a counselling package tested in Bangladesh with positive results. (p.17) ● Globally, maternal mortality is the second largest cause of deaths among adolescent girls aged 15 to 19. Of all births globally each year, around 16 million (11 per cent) are among girls in this age range; about 2 million are among girls under the age of 15. Stigma, discrimination, judgmental treatment, lack of confidentiality, and inability to physically access services are important barriers to care for adolescent girls. Health systems have to be more responsive to their needs. Building on its expertise in supporting first-time young mothers, the MHTF will support countries to improve access among adolescent girls to broader sexual and reproductive health services. It will, for example, focus on developing the capacity of health workers, especially midwives, in adolescent-friendly integrated sexual and reproductive health services; on documenting the experience of care among adolescents and youths in EmONC facilities; and on auditing reviews of maternal deaths among adolescent girls and youths. Outreach and non-facility-based services are critical to reach adolescents, so the MHTF will also support stronger links between EmONC facilities and peripheral health facilities and communities. (p.18) ● Interventions tagged to “equity in access, e.g.:” <ul style="list-style-type: none"> ○ Design the national EmONC facility network using GIS technology to prioritize facilities and analyse referral links between basic and comprehensive facilities (6.1) ○ Provide technical assistance for addressing referral links between com- prehensive and basic EmONC facilities, and with peripheral facilities (6.4) ○ Support the work of midwives as a team in providing SRH services in EmONC facilities (8.2) ○ Support initiatives to prevent obstetric fistula and enable more women and adolescent girls to access quality treatment (13.2) | <p>UNFPA, MHTF Business Plan Phase III 2018-2021, 2018</p> |
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| Regional | |
| <ul style="list-style-type: none"> ● No observations | |

Bangladesh

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| <ul style="list-style-type: none"> ● UNFPA is ensuring care for marginalized and vulnerable groups across the country. This has included establishing maternity waiting homes, as well as water transport to and from facilities in remote hilly areas. Tea garden communities have been supported through training community health workers on maternal health counselling and supporting courtyard meetings. Midwives were placed in selected government facilities near tea garden communities and paramedics in teagardens were provided skills training in quality MNH services. As a result, the number of marginalized women receiving services has increased. | <p>UNFPA, 2018 Annual Report - Bangladesh, 2019, p.2</p> |
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| <ul style="list-style-type: none"> ● The IsDB and UNFPA/ Campaign to End Fistula on 13th March 2018 co-hosted a panel discussion entitled “Preventing the Preventable: Reaching Rural Women and Girls through Obstetric Fistula Initiatives” - Improving rural women’s access to | <p>UNFPA, Campaign to End Fistula Newsletter - April 2018, 2018, p.3</p> |
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| maternal health services contributes to significantly protect them from being susceptible to preventable maternal morbidities. The panel focused on innovative approaches through obstetric fistula (OF) initiatives being used by partners to reach rural women and girls, while raising awareness on high potential OF eradication efforts, exploring evidence, experiences (from Bangladesh and Afghanistan), opportunities and challenges for scaling up OF efforts and getting OF related prevention and comprehensive treatment services to rural women. The importance of partnerships and coordination were reiterated as critical in improving the effectiveness in advancing OF eradication efforts. | |
| Benin | |
| <ul style="list-style-type: none"> Le volet innovation du MHTF a pour but de rendre les produits disponibles au dernier kilomètre (« last mile ») | Entretien, UNFPA bureau pays |
| <ul style="list-style-type: none"> L'engagement communautaire et l'utilisation du numérique pour atteindre cette population jeune qui n'est pas forcément accessible, c'est vraiment un plus dans l'offre du programme de l'UNFPA. | Entretien, Partenaire Technique et financier, organisation multilatérale Août 2021, Benin |
| <ul style="list-style-type: none"> Voir EQ sur l'intégration pour plus de détails sur les programmes SSARJ | |
| Sudan | |
| <ul style="list-style-type: none"> Quality improvement is needed to encourage women to attend public health services especially for deliveries. "The concept of respectful maternity care is "completely absent". EmONC aimed at addressing trust and quality. | Webinar presentation, FMOH, Khartoum, 17 June 2021 |
| Low demand; lack of trust <ul style="list-style-type: none"> Low demand for services: Community itself has low level of demand. | Interview, research/practitioner, Khartoum, Sudan, 15 June 2021 |
| Communication insufficient <ul style="list-style-type: none"> What needs to be discussed in Sudan is why do women give birth at home? No behaviour change or campaigns to explain to women why to attend at a clinic. People don't trust the health system. But there do not seem to be campaigns to change this or a focus on the rights of patients to quality care or dignity. The situation in Sudan is difficult; few referral services and women give birth at home. UNFPA does relevant work. "I believe they do try to focus on the most targeted and needed tasks including for vulnerable women." But there are so few services, the majority of women need access and equity and coverage. | Interview, partner to UNFPA Sudan, Khartoum, June 10 2021 |
| <ul style="list-style-type: none"> Given the challenges related to quality of care and efforts to create a "respect for the patient" culture in Sudan (FMOH quotation), what are the ways UNFPA can best support progress? "We are far behind this concept in Sudan. Considerable and sustained efforts are needed to work on this. This is a long-term investment. But we need to start now as this investment needs a long time." | Comments, RH team, UNFPA CO, Khartoum, Sudan, 23 June 2021 |
| Some services for vulnerable are progressing <ul style="list-style-type: none"> Youth engagement in SRH/COVID-19 awareness campaigns ensured that SRH/COVID-19 response plans are sensitive and responsive to youth-specific needs and expectations. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, UNFPA, Khartoum, Sudan, 2020 |

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| <ul style="list-style-type: none"> ● Monitoring through direct regular supervision and regular meetings with heads of units. The hospital has also made a committee for regular assessment of the work and planning in order to address the needs and fill the gaps. There has been some improvement in services delivery with regards to sustainability, quality and outcomes. | Interview, Referral Hospital Medical Director, Sudan, 5 June 2021 |
| <p>Barriers to reaching the most vulnerable</p> <ul style="list-style-type: none"> ● Shortage of health workers, low level of drug supply and family planning commodities, especially those covered by national health insurance (free of charge). ● No place for 24-hour admission of patients or those who need special care for 24-hour care. ● Clean Delivery Kits are not regularly available although demand remains high. | Interview, PHC Service Provider, Blue Nile State, Sudan, 7 June 2021 |
| <p>Vulnerability of fistula survivors</p> <ul style="list-style-type: none"> ● Survivors of obstetric fistula in Sudan are overwhelmed with the social and economic instability for decades. Darfur traditionally had the largest numbers of fistula cases in Sudan followed by Blue Nile and Kordofan, due to the combination of lack of access to even basic delivery care as well as early marriage and childbearing this has been further exacerbated by lack of access to services due to insecurity during the height of the armed conflict. ● The current obstetric fistula data reported by all the Darfur State Ministries of Health showed that near to 366 fistula survivors “are waiting for surgical repair and we expect that more cases are not discovered yet.” | UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan. p.1 |
| <p>Improving quality needs resources</p> <ul style="list-style-type: none"> ● To improve the service, we are in bad need of neonatal care capacity building for health providers including doctors and nurses ● Rehabilitation of the health facilities especially the building as the condition worsens every rainy season ● Need more training, recruitment, and retention of the midwives due to a high rate of turnover. ● Referral of cases: the hospital has no ambulance. | Interview, SMOH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| Togo | |
| <ul style="list-style-type: none"> ● UNFPA entretient un dialogue permanent avec le Ministère de la santé pour le recrutement des sages-femmes Finance la reconnaissance des sages-femmes méritantes | UNFPA staff, UNFPA, June 2021, Togo |
| <ul style="list-style-type: none"> ● Toutes les actions que les nations-Unies font au Togo, c’est amener le gouvernement à augmenter son budget. Dans le PNDS, la santé maternelle figure en bonne place pour pouvoir bénéficier de financement conséquent. | UNICEF staff, UNICEF, June 2021, Togo |
| <ul style="list-style-type: none"> ● Sur un constat que les services planification familiale quand bien même subventionnés et à frais réduit une limite reste inaccessible à une franche des bénéficiaires, UNFPA appuie actuellement et ce depuis 2010, leur offre gratuite, à travers des campagnes et l’offre foraine. Cependant l’offre en poste fixe reste payante et celle-là qui objet de plaidoyer actuellement. | UNFPA staff, UNFPA, June 2021, Togo |
| <ul style="list-style-type: none"> ● Nous faisons la sensibilisation dans la communauté dans tous les domaines. Nous faisons la sensibilisation en CPN, accouchement en milieu hospitalier par un personnel qualifié, planification familiale. Nous faisons les sensibilisations à tout moment. Surtout à chaque consultation prénatale, nous faisons une causerie aux femmes enceintes qui se présentent à nous. Pour les sensibiliser nous choisissons un thème pour la causerie et cela se fait à chaque début de consultation prénatale, | Midwife, Government, June 2021, Togo |

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chaque jour (Sensibilisation dans la communauté sur différentes thématiques). En CPN par exemple, il y a la CPN recentrée. Au cours de ces visites, nous sensibilisons sur le paquet de services que les femmes doivent recevoir en CPN, la prévention du paludisme, l'utilisation de la moustiquaire imprégnée, la planification familiale, la préparation à l'accouchement, il y a beaucoup de chose (Sensibilisation pendant les CPN sur différentes thématiques).

- Je vais me concentrer sur **l'éducation sexuelle des adolescents**. Comme vous le savez les adolescents ont un paquet de service qui est bien différent des personnes adultes. Nous faisons un effort pour les recevoir et les prendre en charge mais ce n'est pas encore ça parce que leur service doit être vraiment adapté mais nous n'avons pas de local spécifique, nous n'avons pas d'endroit pour recevoir les jeunes (Absence de local pour recevoir les adolescents spécifiquement). Pour la prise en charge du nouveau-né nous n'avons pas de pédiatrie ici. Lorsque la médecine à notre niveau ne peut pas les prendre en charge, les nouveaux nés sont référés au CHR. Il y a des efforts à faire pour prendre en charge toute la population ; je pense qu'il y a beaucoup à faire. Nous n'avons pas un service d'hospitalisation ici ça aussi s est un effort à faire pour que le travail soit vraiment un paquet complet (absence de pédiatrie et d'hospitalisation.).

Uganda

Addressing the needs of adolescents

- UNFPA is also working with two local governments to scale an innovation called **GetIN application** aimed at increasing access to maternal health services by pregnant adolescents through timely identification and systematic follow-up of the girls in their communities. UNFPA, with support from Korea International Cooperation Agency (KOICA), Swedish International Development Cooperation Agency (Sida) and Danish International Development Assistance (DANIDA), is implementing a 'Live your Dream' Campaign targeting adolescents and young people based on the fact that adolescent and young people have dreams and inspirations to act on and realize their dreams. A multi-channel approach is used to engage communities in dialogue to address factors that lead to exploitation of girls and young people and hence prevents them from attaining full potential. 'Live your Dream' campaign is premised on four strands namely: 'Letting Girls to be Girls, Choosing Books before Babies, enhancing youth participation in policy advocacy and programming ('For Youth') and bringing generations together (Generation for Generation - G4G).
- **Roll out of the Get-In mobile App for adolescent mothers in two districts.** A total of 1683 adolescent pregnant girls/mothers were mapped and mobilized for ANC services for the year 2018. Out of those, 846 (50 per cent) are age 15-19 years, 672 (40 per cent) are age 20-24 years and 165 (ten per cent) above 25 years. The findings also indicate that 750 had completed 4 ANC attendances and delivered; besides the number of abortions has reduced and more girls are giving birth at health facilities. This has done in the districts of Rukungiri and Bundibugyo. 137 trained Health workers engaged to identify, register and follow up young mothers for safe birth. There is continuous monitoring and end evaluation will be done
- **First time young mothers:** MoH, with support from UNFPA and relevant partners, is carrying out a Landscaping exercise for adolescent health using the adapted UN tools. The priority bottleneck for adolescent health in the Promise - Renewed was to prioritize evidence-based programming, emphasizing collective action and creation of an enabling environment to ensure that

UNFPA Uganda, 2018 MHTF Annual Report, 2018

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interventions are guided and implemented within the five-priority strategic framework. Findings from the landscape analysis will serve as a national snapshot and will facilitate more effective planning, resource mobilization and implementation for adolescent health in the Country. It will also give an opportunity to understand adolescent policy environment, help drive the health sector to better results for Adolescents (10-19) through critical changes in programming.

- **GetIN Mobile** is a digital mapping tool used by health and community workers to map and follow- up young pregnant girls to ensure they deliver safely at health facilities was introduced in Bundibugyo district in August 2018. Since, there has been a notable improvement in the number of pregnant women and girls seeking skilled health care at delivery.
- **GetIN’s introduction and implementation** in Bundibugyo district aimed to increase the number of girls who attend all the recommended four ANC services to ensure more safe deliveries at health facilities and improve maternal health. Two months after the launch, trained midwives and Village Health Teams (VHTs) mapped more than 400 pregnant girls into the system. Today, over 770 mapped girls all followed up to ensure that they attend all the four recommended ANC visits and give birth in health facilities.
- **A notable increase in the number of pregnant women seeking for maternal health services** Busaru HCIV, Butama HCIII, Burondo HCII and Bubukwanga HCIII. Some of the mapped girls have also started delivering at the different health facilities with PNC given to them accordingly.

UNFPA Uganda, News accessed from:
<https://uganda.unfpa.org/en/news/getin-mobile-app-improves-maternal-health-bundibugyo-district>. August 2019

- “During the CP8, Uganda experienced an unprecedented **influx of refugees, mainly from South Sudan and the Democratic Republic of Congo**, much more than had been anticipated at the time of designing of the CP8. The evaluation indicated that the Uganda UNFPA CO particularly responded rapidly, effectively and efficiently to the increasing **humanitarian challenge** over the years; enabled by their field presence as well as strong partnership with other partners, especially government and other UN agencies.” (p.25)
- **All humanitarian settings have MISP implemented** as per the defined package by the SPHERE project. With support from UNFPA, MISP was implemented in the nine major refugee settlements (Arua, Moyo, Yumbe, Adjumani, Kiryandongo, Rwamwanja, Kyangwali, Nakivale and Oruchinga) for the three major refugee influx emergencies from South Sudan, DR Congo and Burundi.¹³⁶ As a result of the above, the affected population especially women and girls were able to access SRH information and services, adolescent SRH services, family planning services, emergency reproductive health kits and dignity kits. (p. 36)
- “The main challenges encountered in maternal health **were inadequate funds which limited the implementation coverage**; human resources issues related to recruitment; poor staff retention and staff absenteeism which affected accessibility and quality of services; stock out of commodities, supplies and equipment at service delivery points hence hindering the provision of a method mix and quality services; bureaucracy at implementing partner level delayed implementation of interventions”. (pp.36-37).

UNFPA Uganda, GoU and UNFPA 8th Country Programme 2016-2020 Evaluation Report, 2020

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| <ul style="list-style-type: none"> • “The GoU made clear policy commitments to address GBV and the national policy set out clear mandates for government and other actors. Policies were also supplemented by a set of useful guidelines and protocols. However, there were resource and capacity constraints to implement the policies and guidelines.” (p.90) | |
| Zambia | |
| Disability inclusion | |
| <ul style="list-style-type: none"> • “Close collaboration with the Zambia Library for Persons with Visual Impairment led to effective mainstreaming of disability into the country programme. Going forward the CO will leverage and maximise on this to advance availability of and access to relevant SRH communication material to persons with visual impairment.” | UNFPA, Zambia. 2019 Annual Report. 2020, p.3 |
| <ul style="list-style-type: none"> • UNFPA provided technical and financial support to the MoH to finalize and disseminate its first Reproductive, maternal, New-born, Child, Adolescent Health and Nutrition (RMNCAH&N) Communications and Advocacy Strategy geared to increase coverage and utilization of RMNCAH&N services. | UNFPA, Zambia. 2018 Annual Report. 2019 |
| <ul style="list-style-type: none"> • A disability inclusion module for pre-and in-service training of healthcare providers was developed. Selected IEC materials were developed in Braille to facilitate provision of SRH information to persons with visual impairment. | UNFPA, Zambia. 2019 Annual Report. 2020 |
| Addressing teen pregnancy and early marriage: | |
| <ul style="list-style-type: none"> • UNFPA developed two concept notes designed to address issues related to teen pregnancy and child marriage: <ul style="list-style-type: none"> ○ UNFPA Zambia and Restless Development: Research to gather evidence on the phenomenon of child marriage, teenage pregnancies and SGBV looking at the causality links between teenage pregnancies, early marriage and socio-cultural norms; decision-making pathways leading to teenage pregnancies and child marriage; bottlenecks to preventing teenage pregnancies and child marriage, especially in relation to SGBV. ○ UNFPA Zambia proposed a multi-sector approach to increase access to and retention in education; strengthen the health system’s capacity to reach out to adolescents for sexual and reproductive health services; regulate through formal and customary legal systems the age of marriage; utilize community-based counselling to identify and respond to vulnerabilities and risks; and strengthen formal and informal community support structures to challenge social norms. It would support the implementation of the national strategy to end child marriage through a joined up multi-sectoral approach in 15 districts. The funds would provide specific support to strengthening the quality of services provided and the linkages between the sectors in tackling multiple deprivations facing vulnerable children and their families which lead to child marriage. • The status of these concept notes is unknown. | <p>UNFPA Zambia and Restless Development. Concept Note: Teenage pregnancy and child marriage research in Zambia – Decision-making pathways and influence of GBV on ASRH outcomes. December 2019.</p> <p>UNFPA Zambia. Our Future, Our Choice: Transforming the lives of adolescents in Zambia. Draft Concept Note. September 2020.</p> |
| <ul style="list-style-type: none"> • “The data on teenage pregnancy is not good; it has remained the same at 28-29 percent. And we know that these young girls who are getting pregnant are more likely to develop complications, they are more likely to drop out of school. It is a ripple situation that comes out from teenage pregnancy.” | Interview, MoH Zambia national staff/ August 2021 |
| Online survey | |
| <ul style="list-style-type: none"> • No observations | |

| Assumption 6.3: UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged | |
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| Indicator: | |
| <ul style="list-style-type: none"> Trends in data on MNH and SRHR service utilization, disaggregated by age, ethnicity, wealth, geography, and other available indicators⁶ | |
| Observations | Sources of Evidence |
| Global | |
| <ul style="list-style-type: none"> No observations | |
| Regional | |
| <ul style="list-style-type: none"> No observations | |
| Bangladesh | |
| <ul style="list-style-type: none"> UNFPA is ensuring care for marginalized and vulnerable groups across the country. This has included establishing maternity waiting homes, as well as water transport to and from facilities in remote hilly areas. Tea garden communities have been supported through training community health workers on maternal health counselling and supporting courtyard meetings. Midwives were placed in selected government facilities near tea garden communities, and paramedics in tea gardens were provided skills training in quality MNH services. As a result, the number of marginalized women receiving services has increased. During the reporting period, 1,509 deliveries were conducted by the skilled births attendants, 1,597 women received fourth ANC, 534 women received PNC within two days after delivery, where 338 received PNC within 24 hours (PNC-1), and 349 women were referred from teagarden facilities to higher level facilities. | UNFPA, 2018 Annual Report - Bangladesh, 2019, p.2 |
| Benin | |
| <ul style="list-style-type: none"> Voir EQ sur l'intégration pour plus de détails sur les programmes SSARJ | |
| Sudan | |
| MHTF investments | |
| <ul style="list-style-type: none"> Most supplies are provided under other programmes including commodities under the UNFPA Supplies Programme and RH kits and midwifery kits under different humanitarian funding streams such as the Central Emergency Response Fund. Sudan has a range of complex humanitarian settings such that it received humanitarian support in each of 2018, 2019, 2020 and 2021. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| Politics and equality | |
| <ul style="list-style-type: none"> "Women's rights are part of the political game and there is a need for keeping the political balance and that affects the government and its decisions" UNFPA understands and is sensitive to the fact that there are political, policy, systems, socio-economic, cultural and other factors that affect how vulnerable and marginalised groups access basic services. They can do some things but not all things. | Interview, Partner to UNFPA Sudan, Khartoum. 7 June 2021 |
| Governance impacts equity even with UNFPA support | |
| Interview, National NGO, Khartoum, 3 June 2021 | |

⁶ Given the COVID-19 pandemic, it is unlikely that data will be available for 2020; however, anecdotal information may be useful here to capture the implications of COVID-19 for maternal care.

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| <ul style="list-style-type: none"> UNFPA supported partners face challenges delivering integrated RH services to rural or harder to access places due to weak coordination between localities and state authorities, and between different directorates within the SMOH. | |
| UNFPA funds mobile services for outreach <ul style="list-style-type: none"> We mobilize mobile clinic for outreach areas providing both antenatal and family planning and other services and have stepped up support to midwifery cadres to perform safe delivery to COVID-19 patients. | Interview, Director, National NGO, Khartoum, 3 June 2021 |
| <ul style="list-style-type: none"> UNFPA supports provision of PHC services through mobile clinics especially to humanitarian areas and refugee camps service includes GBV services. | UNFPA Group Meeting, 5 June 2021, Khartoum |
| UNFPA supports HIV services for adolescents and vulnerable women <ul style="list-style-type: none"> UNFPA mainly support CAFA to work in the area of HIV, including community awareness, youth engagement, capacity building for health workers especially on performing safe delivery for HIV positive women, awareness of vertical transmission of HIV and support to many Peer Driven Intervention Centres. Providing HIV and STI services. Centres are mainly located in Khartoum, Blue Nile and White Nile states. | Interview, Director, National NGO, Khartoum, 3 June 2021 |
| Low demand for services a hindrance <ul style="list-style-type: none"> The community itself has a low level of demand. Preference is for home delivery as “they believe it is less expensive and there may be issues of quality and trust”. Community health midwives deliver these babies and in Blue Nile they are much more often untrained birth attendants working in the community. For example, in 42 areas, services are provided by untrained midwives (unskilled birth attendants) who have not had even the basic training that was suspended some years ago. | Interview, Director of MNH Services, SMOH, Blue Nile, Sudan, 8 June 2021 |
| UNFPA, including MHTF, supports complex setting in Sudan <ul style="list-style-type: none"> UNFPA is highly valued and much appreciated in Sudan where needs are high, resources limited and as a result of the context, much of the support is directed to refugees and humanitarian needs rather than delivery of essential health services through normal channels. | Interview, RH Coordinator, FMOH, Khartoum, Sudan, 1 June 2021 |
| Geography and roads affect access <ul style="list-style-type: none"> It was not easy at all to get to the clinic considering the lack of available transport and the high cost of transportation. | Interview, community member, Blue Nile State, 8 June 2021 |
| Lessons learned to increase access and utilization in emergencies <ul style="list-style-type: none"> Early engagement in the response to different types of emergencies including floods, haemorrhagic fever, local conflicts and influx of Ethiopian refugees helps in addressing the needs of women in reproductive age and facilitate their access to services. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| The MPDSR-linked research identifies where equity falls short <ul style="list-style-type: none"> Although magnesium sulphate is now available in most of the states, it is not well utilized for treatment and prevention of severe pre-eclampsia and eclampsia in most of the states, 70 per cent received magnesium sulphate in this report. Although since 2015, midwives have been authorized to use magnesium sulphate and uterotonics under supervision for reducing maternal mortality from obstetric haemorrhage and hypertensive disorders, implementation of this policy is still limited to two pilot states and the results have not yet been disseminated or implemented across other states. | UNFPA, Maternal Death Surveillance and Response Report, 2018, UNFPA Khartoum, Sudan. p.8 |

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| <ul style="list-style-type: none"> The evidence has shown that the availability of trained midwives had the highest protective effect on maternal death reducing case fatality by 80 per cent. | |
| UNFPA, including through MHTF, directs resources to reducing harmful practices: <ul style="list-style-type: none"> Providing of family planning, skilled birth, lifesaving services at birth Reducing the harmful traditional practices, particularly FGM | Maternal Death Surveillance and Response Report, 2019, Khartoum, Sudan. p.7 |
| Togo | |
| <ul style="list-style-type: none"> Il n’y a pas un mécanisme qui est mise en place. C’est juste une approche où un patient peut parler à un prestataire de la situation qu’elle a vécu et le retour ça nous regroupe. il n y a aucun mécanisme qui est mise en place. Nous prenons les informations, après analyse de cette information, je sais que les responsables ont des mécanismes. Je sais que les responsables ont des mécanismes pour faire des évaluations et prendre des décisions après. | Midwife, Government, June 2021, Togo |
| Uganda | |
| <ul style="list-style-type: none"> 33 per cent of girls gave birth before the age of 18 (6.6 per cent gave birth before age 15) Per cent of girls aged 15-19 who are in a marriage/union and are not currently using contraception = 86.1 per cent Per cent of women and girls, aged 15-24, who think that wife beating can be justified ranges from 45.3 per cent in Kampala to 74.8 per cent in East Central region | UNFPA Dashboard on adolescent and youth/Uganda, Accessed from https://www.unfpa.org/data/adolescent-youth/UG |
| Service provider perspectives on challenges to equitable access <ul style="list-style-type: none"> This is a mixed setting with refugees and host population, with language differences, it is difficult for midwives to take notes and refugees are not comfortable with people that do not speak their language. If delivery kits not available, mothers feel embarrassed – they do not want to be naked, the delivery kit help them (cover themselves) because there is towel, kitenge. There is very limited space and lack of equipment: Maternity/delivery room is very small; PNC is sometimes used for admissions, because there are too many clients. The oxygen cylinder is not there, and that is very crucial in managing severe asphyxia. There are no security lights, behind the maternity ward it is very dark, and the bathrooms and toilets are very dark, and the women fear going there, so just urinate outside, close to main building. During raining season, there is nowhere to stay for adolescents. There are inadequate staff to serve a big population – the number of health workers is not enough. So sometimes the waiting hours are very long, because one health worker is attending to many clients. The facility covers a very large geographic area – it is impossible to reach all the outreach points during the month and there is limited funding to cover all of them in a month (as per standard plan) – e.g., if you immunize a child today, and the next vaccination is the next month, and immunization schedules cannot be respected. Traditional birth attendants are still convincing the mothers to stay at home. Currently no partner supports a strategy to engage/educate traditional birth attendants. (Note: the government discourages/prohibit the use of traditional birth attendants and thus no/few partners even integrate them within other programmes). | Interview, Service providers, Lawmo District, Uganda, May 2021 |

Assumption 6.3: UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged

- Also, during labour time, some mothers are still very far, and their partners are not supporting them. It would be good to promote community referrals through the use of the ambulance – because the husband will not give transport to go to the facility. But the biggest challenge is network within the facility – we have poor network connection – so sometimes they cannot reach us to call for the ambulance – that is the still the biggest challenge.
- Another challenge is that some of the midwives stay outside the facility – they have to rent somewhere else – **there is not enough accommodation at the health facility compound**. MoH is supposed to provide housing within the health facility – so the midwife can quickly come in times of emergencies – but if she is far away, it is difficult for her to come her, e.g., if you need extra support for a complicating case – but you cannot call someone, come in the middle of the night, it is too risky.
- **Another challenge is the follow-up of GBV cases** – at two weeks, four weeks etc. Sometimes after getting the first service, they get lost in the village, and we cannot track them. There is no support to do follow-up or home visits to check on how they are doing, because sometimes they are still stigmatised. After registering the case at the police, there is often no follow-up, maybe the perpetrator is free again, so they think that no one is giving them justice (and it is not worth it), and sometimes they fear coming back to the health facility because of stigma. So home-based care and visits would be a better strategy

Client perspectives on access to service delivery

- **Transport vouchers help** get to the service via ambulance by paying for fuel. Some walked to the clinic by foot (1.5 hours).
- Some indicated that they were **informed by friends/neighbours to go for early ANC**, and they received drugs and nets to prevent malaria. VHT members hold community meetings and encourage women to go for early ANC. One woman said she did not get a net because the midwife did not have a key to the storeroom. Others **complained about out-of-stock medicines**.
- Some women indicated **they were never informed about family planning** while others said they were educated during pregnancy and after birth or during her baby’s first immunization visit.
- A few women noted that the **midwife refused to see them because they came without their husbands**. The provider indicated that for the first visit the women must come with her husband.
- When asked what to improve, respondents noted that there needed to be more staff, the service providers need training on how to talk to clients without being rude, stockouts (medicines, maternity kits) need to be addressed, the facility’s hygiene and cleanliness needs to be improved.
- After delivery, midwives tell women to get 40 litres from the borehole to the clinic before you can be discharged because the facility is not hooked up to water.
- Women’s stories:
- “I was 16 when I got pregnant. I **always came for ANC** here at the facility. When I came to deliver, I had complications, the baby had problems.” With the **help of the ambulance**, they rushed her to Kitgum government hospital. “The health workers from here, they did not go with me, but they continued to **communicate with me on phone, to see how the babies was doing.**”

Group discussions with women and girls, Lawmo District, Uganda, May 2021

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| <ul style="list-style-type: none"> • “When I came here, they welcomed me, they did not delay me, they took me straight to the labour place, where they taught me what I should do, to get safe delivery. However, I had personal fear, since it was my first delivery. But with the midwife they rushed to help me, did not delay me.” • Whenever I come here for ANC, the midwives always take us very well, they do not delay, even if we are many, they serve all of us, and they do not delay in attending to us. The midwives from this facility are really social, they really help us and support us. They always give us advice, teach us, always encourage us not to fear during the time for delivery.” | |
| <ul style="list-style-type: none"> • UNFPA in liaison with MoH commissioned a study in 2018 to identify these groups and the metaphor of an “onion-peeling” helped to unravel the layers of hard-to-reach as they emerge from the broad categories of hard-to-reach groups: <ul style="list-style-type: none"> ○ Hard-to-reach are forgotten by omission, stereotyping, exploitation or due to geographical location, policy and other structural factors. ○ Harder-to-reach can be categorized as those individuals who, for some reasons, are disengaged by marginalization. These groups lack an active voice and place in society. Examples include mountain communities, and nomadic/pastoralist communities (Karamoja region and other districts in the cattle corridor). They may be difficult to reach but not disengaged or hard to hear. ○ The hardest-to-reach often identify with the marginalized groups, but due to their intersecting identities, they may experience further marginalization and isolation. Limitations on these individuals may be imposed by existing national policies and laws, Examples of people in this category include drug users, individuals with different sexual orientation, girls subjected to FGM whose families keep them from public view to avoid legal consequences. • The evaluation recommended that, in order to strengthen equity, the human rights-based approach and leaving no one behind, the next CP should actively advocate for use of the differentiated service delivery model to facilitate effective response to the peculiarities of needs and diverse contexts of hard-to-reach populations and communities. Service delivery and programming models for the general population are generally not effective for reaching hard to reach communities such as nomads, people with different types of disabilities, fishing communities, people leaving in mountainous areas, most-at-risk populations and the LGBTI. There are lessons learnt from HIV/AIDS programming that could be adapted for use to meet the need for these groups. | UNFPA Uganda, GoU and UNFPA 8th Country Programme 2016-2020 Evaluation Report, 2020 |
| Zambia | |
| MHTF resources directed to underserved provinces | |
| <ul style="list-style-type: none"> • UNFPA has directed its resources to three provinces (Luapula, Western and North-Western) where there were few healthcare providers offering services. Health facilities were unmanned by unqualified staff. UNFPA embarked on the training of midwives and nurses, as they are key for MNH service provision. | Interview, Multilateral organization national staff. August 2021. |
| <ul style="list-style-type: none"> • UNFPA supports activities in the Western, Central and North-Western provinces. “And these have places that are hard to reach, so they’ve made a very good attempt at least to reach those areas in an attempt to have equity. For example, Western province is an area that is mostly desert-like. It is sandy, it is very, very difficult to reach. They have trained midwives who have been posted in those facilities where women have not been able to have access these health services.” | Interview, MoH Zambia national staff. August 2021. |

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- **UNFPA is now the only organization that is directly supporting at the level of human resources, in their focus provinces, supporting the government to do midwifery training and placements.** The approach is to work in the places where the systems are weaker, and identify local girls, send them to school and then contract with them to stay. In the Western Province, UNFPA has its “foot on the ground.” It is a very poor, rural province.

Interview, Multilateral organization national staff. August 2021.

Humanitarian response (non-MHTF funded)

- **UNFPA worked to ensure women, adolescent girls and young people in refugee settlements in Nchelenge had access to quality health care, in line with the UNFPA “Safe Birth Even Here” campaign and as part of the UN Zambia joint response to the DRC emergency situation** funded by the UN Central Emergency Response Fund (CERF).
- Nchelenge District (Luapula Province) hosted over 13,600 refugees who fled the DRC. “Over 70% of the refugee population is comprised of women, including 50% women of reproductive age. Among these over 400 were pregnant and faced increased risks of complications due to limited access and uptake of quality services.” (p.22)

UNFPA Zambia. 2018 Annual Report. 2019.

Area of Investigation 7: Catalytic role

Evaluation Question 7: To what extent has the MHTF fulfilled its catalytic role enabling UNFPA to ‘punch above its weight’ in support of MNH outcomes and integration with SRHR?

Sub-questions:

- a) To what extent has UNFPA used the MHTF as a vehicle to play a broker role for the promotion of MNH and wellbeing in high MMR countries, improving coordination and partnerships, leveraging more funding from both international and national sources, and providing effective strategic direction, technical assistance, and capacity building through country-driven interventions?
- b) To what extent has the MHTF leveraged a range of discernible, tangible, and practical results, including political commitments and policy support and financial commitments and investments
- c) To what extent has global and regional technical support from UNFPA supported country teams and national health authorities through strengthening reliable data and information collected through monitoring and review, stimulating knowledge sharing approaches, and identifying, scaling-up or replicating innovation and good practices within and between countries?

Evaluation criteria

Relevance, efficiency, coordination

Rationale

Catalytic is defined as an agent that provokes or speeds significant action. In this evaluation, catalytic actions are those that are assessed to provoke or accelerate relevant change or progress. A catalytic role is therefore one that identifies, promotes and advances those actions. There is an implied counterfactual which is that without the catalytic investment, significant change would not have occurred or would have occurred only very slowly. Given its wide scope, its relatively low resource envelope, its commitment to sustainability, equity, human rights and gender equality, the MHTF gains more traction and achieves better results if it concentrates its effort on catalytic investments and actions, playing a broker role within UNFPA and with external partners, and sparking political, programmatic and financing commitment beyond its own investments. Catalytic support includes using the UNFPA mandate to good effect, focusing on its role to strengthen partnerships, coordination, strategy and capacity building, and extending innovation through knowledge management strategies including the identification of best practices.

Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding

Indicators:

- MHTF engagement in or support to strategy, policy and planning development especially involving other partners and players to forge partnerships and negotiate coordinated approaches and strategies including the allocation of roles and responsibilities
- Examples of UNFPA convening partners to assist with the development of costed maternal health approaches and strategies including national plans
- Examples of UNFPA leadership or coordinated working with other country level partners to provide effective strategic direction, technical assistance, and capacity building through country-driven interventions
- Examples of MHTF support to UNFPA intervention to bring partners together around plans, ideas, proposals, strategies in ways they otherwise would not have and to allocate additional resources, focus, effort to these

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| <ul style="list-style-type: none"> ● Specific examples of how MHTF at global level or through support to UNFPA CO efforts at country level helped negotiate the involvement of new partners, increased resources, better approaches, or innovations to support/ fund MNH at any level (global, regional, or country) ● Clear definition of the role and approach of UNFPA to working with SDG3 GAP agencies at country level especially on MNR related activities and plans. | |
| Observations | Sources of evidence |
| Global | |
| <ul style="list-style-type: none"> ● Launching a global process to revise the EmONC framework, AMDD will continue as the chair of a global TWG to guide the revision of the EmONC framework, and AMDD will continue to provide expert analysis and advising throughout the consultative process. ● The TWG currently functions with a core group with representatives from UNFPA, WHO, UNICEF, Every Newborn Action Plan (ENAP)/London School of Tropical Medicine and Hygiene, and AMDD and communicates with a larger group of approximately 20 additional UN agencies, bilateral funders, NGOs, academics and other stakeholders. As chair of the TWG, AMDD will produce summaries of calls and meetings, and will develop consensus plans for the overall revision process. ● The TWG efforts will continue to link to and complement – not duplicate – ongoing measurement-related initiatives related to MNH including the SDGs, Countdown 2030, ENAP, Ending Preventable Maternal Mortality (EPMM), Quality-Equity-Dignity (QED), MONITOR, and the Global Strategy for Women’s, Children’s, and Adolescents’ Health. | <p>Columbia University and AMDD, Concept Note for Columbia University/Averting Maternal Death and Disability Program, 2019, University of Columbia, New York, 2020</p> |
| <ul style="list-style-type: none"> ● Fragmentation of the SRHR – MNH agenda: the SDGs create the means to link the full agenda, but UNFPA allows fragmentation somehow in the way it arranges its funds and programmes. ● Too little focus on maternal morbidities, GBV, and obstetric violence globally. ● We support MHTF because it focuses on MNH but with links to SRHR and is really the only partnership that does that. We do struggle to justify it though because this is core business for UNFPA, and we also give core funding to UNFPA so we would prefer to see more core funding going to maternal health and SRHR integration. ● MHTF covers crucial areas. The strategic partnership with ICM is great and the UNFPA midwifery work is a “big success story”. ● There should be more communication between the midwifery and EmONC teams at the country level. Need to be more strategically linked. | <p>Interview, Global funding partner, July 2021</p> |
| <ul style="list-style-type: none"> ● MHTF and UNFPA – leaders in midwifery. WHO is the normative partner where UNFPA helps with implementation. They complement each other but have different roles. MHTF/ UNFPA is assessed as a reliable partner despite being bureaucratic. Could have better alignment between maternal and newborn (UNICEF). But we shouldn’t talk about family planning without midwives. Safe abortions and post-abortion care, same thing. | <p>Interview, Global Funding Partner, July 2021</p> |
| <ul style="list-style-type: none"> ● UNFPA has a presence in most countries. We think they are best placed to take these programmes forward. We value the inclusive approach to donors and find they are responsive and active. | <p>Interview, Global Funding Partner, September 2021</p> |
| <p>UNFPA not always leading at the global level UNFPA was part of a working group to develop MPDSR materials but according to global partners (and the evidence of the launch event), UNFPA declined to be associated with the results and to participate in the launch. It is unclear why.</p> | <p>Flyer for the launch of newly developed MPDSR tools by the</p> |

Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding

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|  | <p>working group led by WHO and UNICEF</p> <p>Interview with global partner, September 2021</p> |
| <ul style="list-style-type: none"> ● The history of the work that UNFPA has done, the contribution to SRH and women and girls is renowned. Everyone knows their work. People from UNFPA are there; you can see the level of commitment and expertise. I am always telling people the work with UNFPA is the most valuable and central to the mission of the MH initiative. Every bit of work is about improving access to women and girls; such a respected partner, proven organisation. | <p>Interview, Global policy partner, September 2021</p> |
| <ul style="list-style-type: none"> ● Our role/relationship has been very collaborative and positive; at global level there has been a real true collaboration. UNFPA colleagues are trying to champion the work of others so really global efforts. Done a good job of recognizing at the global level. | <p>Interview, Global policy partner, September 2021</p> |
| <ul style="list-style-type: none"> ● At global level, with their leads on innovation and digital solutions – have been very collaborative. At global level, have paved the way for us to enter dialogues at regional and country level. Give them a thumbs up, compared to other UN agencies, there is an openness to new ways of working, i.e., digital solution. ● Would be wonderful to consolidate the engagement under a more strategic MOU or collaboration, not just to seize opportunities as they reveal themselves but to think more strategically – more co-creation with UNFPA. Requires a different modus operandi. Longer-term perspective to give more space for strategic thinking. Project-based, ad hocs that are operational, based on available funding, but not so strategic. Having the commitment from both partners that we are in a strategic partnership. Common goals that stretch over 2-3 years, including joint fund-raising. More and more call for doing this in the future. Co-create is a great concept and solution. | <p>Interview, Global policy partner, September 2021</p> |
| <ul style="list-style-type: none"> ● Astute partnership building by the MHTF to work so closely with ICM. Also, other global partnerships – they are well chosen. | <p>Interview, Multilateral Partner, July 2021</p> |
| <ul style="list-style-type: none"> ● At a global level, coordination with UNFPA is superb. At the country level it seems to depend more on personalities and leadership. | <p>Interview, Multilateral Partner, July 2021</p> |

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| <ul style="list-style-type: none"> ● It would be good to hear more reference to the MHTF and to maternal health generally – in UNFPA presentations and speeches in the global arena especially at the senior level. It seems almost marginalised and is certainly under-represented in UNFPA dialogue and communications. ● MHTF clearly addresses one UNFPA goal, but it is unclear how it relates to other funding mechanisms and policy streams (and goals). There could be better communication about this. More strategic thinking. | Interview, Global Funding Partner, July 2021 |
| <ul style="list-style-type: none"> ● We need more and better communication from MHTF. For example, there is no “year in review” reflection at the end of the year. It is hard to communicate about maternal health interventions anyway – and about the integration of SRHR and maternal health – but we need that for our own internal decision processes and accountability. It would also be useful we think for the MHTF to communicate more and better within UNFPA and beyond. This could include stories from the field for example, more about results that are not just numbers of things. ● The MHTF is already doing a lot and should not expand particularly. | Interview, Global Funding Partner, July 2021 |
| <ul style="list-style-type: none"> ● Global partnership with UNFPA and MHTF in particular, is improving. Very much better in the last year or so. | Interview, Multilateral Partner, July 2021 |
| <ul style="list-style-type: none"> ● Really brilliant that UNFPA has formed this partnership with the ICM – objective, technically sound, focused on quality. ● Relationship with UNICEF seems to be based on lots of coordination but not a lot of practical cooperation. ● But UNFPA does an “amazing job” with the resources available. Maternal health and linking maternal health to reproductive health is vital and they are in the lead on this. Probably not enough on family planning. ● Important to find ways to involve country experts in the global dialogue. To change with the evolution of global health and support the growth of expertise in countries. | Interview, Global Technical Partner, October 2021 |
| Regional | |
| <ul style="list-style-type: none"> ● Regional level is good entry point and MHTF could possibly create more value there. | Interview, Global Funding Partner, July 2021 |
| Bangladesh | |
| <ul style="list-style-type: none"> ● UNFPA was the technical agency which guided government to design the midwifery programme ‘which took off like fire’. | International Midwifery Specialist, UNFPA, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● It was UNFPA advocacy which led to the development of midwifery as a professional cadre, although total ownership of the programme has been given to the government. UNFPA advocacy has also resulted in mainstreaming midwifery in government’s national programme. | Midwifery Officer, Nursing and Midwifery, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● UNFPA is the acknowledged leader of development partners, multilateral agencies and Government of Bangladesh for technical development of midwifery in Bangladesh. It has played this role most effectively, as a result of which within a short time, midwifery which was an absolutely new profession in 2016 is now established in the country and expanding fast. | Adviser, FCDO, Dhaka, Bangladesh, June 2021 |

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| <ul style="list-style-type: none"> ● In 2011, the Prime Minister of Bangladesh made a commitment to deploy 3,000 midwives across the country by the year 2015 which UNFPA has been supporting through the launch of a national direct entry professional midwifery programme in collaboration with the Government of Bangladesh and the establishment of the Bangladesh Midwifery Society (Association) in 2012. | <p>Unknown author, Bangladesh Midwifery Mentorship Programme, unknown year, p.1</p> |
| <ul style="list-style-type: none"> ● The Government of Bangladesh, in association with UNFPA and Save the Children International as a partner, introduced the Strengthening National Midwifery Program in 2017 to initiate midwifery-led model of care in Upazila Health Complexes (sub district hospitals) with the goal of bolstering the quality of midwife care through mentorship. | <p>Unknown author, Bangladesh Midwifery Mentorship Programme, unknown year, p.1</p> |
| <ul style="list-style-type: none"> ● In April 2017, UNFPA collaborated with Save the Children to launch the Strengthening the National Midwifery Program (2017-2021) under the leadership of the MoH&FW to strengthen midwifery education and demonstrate the MLC, particularly at the UHC. | <p>UNFPA, Integration of the Midwifery Services into the Health System, 2018, p 2</p> |

Benin

Un contexte favorable

- Avantage du Benin : **Vision du Ministère de la sante** : Ministre connaît MHTF, fistule, SONU et a une vision stratégique et cela rentre dans une dynamique politique nationale. Plus facile d’atteindre un impact quand on rentre dans un schéma.

MHTF positionné stratégiquement – nature holistique de la stratégie qui couvre tous les thèmes de la SMN et proximité avec le gouvernement

A Vision for maternal and neonatal health/ SDG 3.1

Where does the MHTF make a difference

WHAT: Prioritization & costing/budgeting

HOW: Integration of SRHR

WITH WHOM: Midwives save lives

Entretien UNFPA bureau pays, Mai 2021, Benin

UNFPA Brochure, Benin, 2020

- **Pourquoi et comment le MHTF nous sert stratégiquement** 1) En développant des outils de priorisation et costing et budgeting pour atteindre les 3 résultats transformatifs de UNFPA et ODD, à travers la Cartographie qui montre la couverture des services SONU accessibles par les femmes moins d’1h et à travers le costing des SONU qui offre des propos clairs et documentés sur ce qu’il reste à faire pour atteindre ODD 3.1

Interview, UNFPA CO leadership, Benin, June 2021

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| <ul style="list-style-type: none"> ● Notre stratégie est de capitaliser sur les acquis – mobiliser des ressources à l'international et travailler sur des partenariats solides autour de la santé maternelle et le PAG (Plan d'Action du Gouvernement) pour assurer la complémentarité pour la durabilité | Entretien UNFPA bureau pays, Mai 2021, Benin |
| <ul style="list-style-type: none"> ● Stratégie holistique : Nous travaillons sur la qualité des services : La SDMR nous aide à avoir une image en temps réel des problèmes ; le travail sur les SONU nous avons établi des critères de fonctionnaliste/qualité, y compris en s'assurant que le personnel peut remplir toutes les fonctions signalétiques et que les produits vitaux sont disponibles ; le MHTF nous a permis de savoir que nous n'avons pas assez de sages-femmes – on s'en est rendu compte en essayant de mettre en place le réseau SONU, et on fait du plaidoyer pour que le gouvernement recrute plus de sages-femmes, en ligne avec les normes en vigueur | Entretien UNFPA bureau pays, juin 2021, Benin |
| <ul style="list-style-type: none"> ● Le MHTF propose des interventions qui ont fait leur preuve et permet de passer à l'échelle. Par exemple, les référentiels et la cartographie en matière de SONU aident à engager d'autres PTFs (partenaires techniques et financiers) ; le MHTF aide à disséminer le mentorat. Il aide à maximiser les ressources. Il accompagne le gouvernement en s'appuyant sur des documents produits par UNFPA, pour identifier les zones prioritaires. Il a aidé à trouver des ressources additionnelles telles que le Fonds Muskoka et les fonds Takeda. ● Coordination est un défi : Nécessite de mettre en place un cadre pour se rencontrer et échanger et éviter les doublons – pour travailler sur la synergie. Il existe une structure de coordination (secteur de sante en général – « PTF Sante » (partenaires techniques et financiers)) ; plateforme spécifique à la santé maternelle devrait être mise en place. | Entretien UNFPA MHTF Focal Point Entretien UNFPA bureau pays, juin 2021, Benin |
| Perceptions des acteurs de la SMN sur le rôle catalytique du MHTF | |
| <ul style="list-style-type: none"> ● Si je considère Fistules et SDMR, je peux dire que le programme précédent a joué un rôle vraiment d'avant-garde. Pour les SONU, c'est moins évident. Cela a créé une prise de conscience plus aigüe de la chose et d'autres sont venus. C'est UNFPA qui a vraiment travaillé avec le Ministère pour le pilote et la documentation du processus à travers le CERRHUD. C'est après la validation nationale de ce processus que l'arrêt du Ministre a été pris pour institutionnaliser la SDMR. ● Dans le domaine des SONU, on peut dire UNFPA a joué un rôle fondamental et continue de le jouer. UNFPA constitue un partenaire stratégique du Gouvernement lorsqu'il s'agit de ce sujet-là. On ne peut pas discuter SONU au Bénin sans penser à UNFPA, tout comme on ne peut pas discuter VIH sans penser à ONUSIDA. De là à parler de catalytique, il faut quand même nuancer un peu. Si nous prenons par exemple la formation des sages-femmes, on peut dire que l'existence du financement de UNFPA a drainé celui de ENABEL. Pour les SONU, c'est possible que les autres soient venus parce que UNFPA a fait le travail de base, mais je ne peux pas tirer cette conclusion de façon très ferme. ● Je pense que les problèmes de SMN sont bien connus au niveau national et les dirigeants. On ne peut pas dire que c'est UNFPA qui fait prendre conscience au Ministère des problèmes dans ce domaine. Mais la disponibilité des ressources permet d'engager des processus d'approfondissement des différents thèmes et de réfléchir aux priorités | Entretien agence multilatérale, Juillet 2021, Benin |
| <ul style="list-style-type: none"> ● UNFPA a un rôle catalytique partiel. Il y a un problème de visibilité, cela se passe dans une certaine mesure, pour ceux qui connaissent, UNFPA mettent leur poids pour mobiliser des ressources additionnelles. Les autres se greffent sans pour autant se | Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin |

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| dire que c'est parce qu'il y a le MHTF – beaucoup se disent je comble les manques. Problème de visibilité du MHTF pour lui donner ce rôle-là. Fonds thématiques ont leur effet d'entraînement | |
| <ul style="list-style-type: none"> ● UNFPA est quand même très visible pour tout ce qui est santé maternelle et néonatale. Dans la communauté des PTF, c'est leur mission première dans le système des Nations Unies. C'est de la même manière qu'on voit UNICEF pour ce qui est des enfants. Donc, pour moi, c'est un peu normal [d'avoir un rôle catalytique] | Entretien donneur bilatérale |
| Coordination | |
| <ul style="list-style-type: none"> ● Coordination : Ça se passe bien. Quand on met différents acteurs en commun, chacun tire le drap de son côté. Il faut un peu de fermeté – répéter à tue-tête ou on veut aller et pas là ou ils veulent | Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin |
| <ul style="list-style-type: none"> ● UNFPA dispose de crédibilité auprès des autres bailleurs pour s'engager dans la coordination grâce au travail technique sur les SONU. Attestée par le SWEDD qui a offert l'assistance technique a UNFPA. | UNFPA leadership, Cotonou, Benin, May 2021 |
| <ul style="list-style-type: none"> ● UNFPA ne se positionne pas comme une entité de coordination. La coordination, c'est au niveau du Ministère. Par contre, dans le système des Nations Unies et avec les autres PTF, il est reconnu à UNFPA un rôle important dans le domaine de la santé sexuelle et de la reproduction, des programmes de santé maternelle et infantile. Je dirai que c'est leur marigot. Donc quand on se réunit pour discuter des progrès ou des orientations stratégiques, tout le monde s'attend à ce que UNFPA prenne naturellement le leadership dans ces domaines-là. | Entretien agence multilatérale, Juillet 2021, Benin |
| <ul style="list-style-type: none"> ● UNFPA de mon point de vue c'est un partenaire, ils ne devraient pas porter responsabilité de mobiliser ressources pour nous – on est un état régalien, on devrait prendre notre responsabilité | Interview with multilateral agency, Benin, July 2021 |
| <ul style="list-style-type: none"> ● « Les effets catalytiques centrés sur les programmes », vont de pair avec “un effet boomerang” au niveau du financement de la SM, y compris la levée de fonds privés (Takeda). | Entretien, UNFPA bureau pays, Mai 2021, Benin |
| <ul style="list-style-type: none"> ● Malgré tout, MHTF reste dans un huit clos au niveau global et est trop faiblement arrimé au Global plan. Il faudrait qu'il rentre dans la UN reform et une meilleure intégration avec la composante Human Rights ● Dans vision stratégique, les données sont le maillon faible. Dans quelle mesure le MHTF se positionne sur le domaine digital pour renforcer IMS et proposer un modèle d'intégration des données ? Pour l'instant chacun des domaines intègre à sa propre base de données : l'équipe MHTF n'est pas dans cette conversation ● Financing : Il serait nécessaire de faire un calcul du retour sur investissement : Qu'est-ce que cela rapporte de faire du budgeting des SONU ? En complément, un plaidoyer serait nécessaire pour faire partie des conversations stratégiques sur le financement des ODD. Si on ne participe pas à cette conversation, on ne sera pas financé dans le futur. En bref ; MHTF est un fond structurant techniquement et offre beaucoup de transfert de compétences techniques mais il opère trop en vase clos au niveau du siège et adopte un jargon difficilement compréhensible. ● Le MHTF devrait forger des partenariats au niveau global et régional avec le Fonds Muskoka et la programme SWEDD de la Banque mondiale, en jouant sur la complémentarité du FM et MHTF, qui sont pour l'instant « comme deux chevaux galopant en parallèle ». Etant donné que le programme SWEDD couvre 9 pays, il semblerait logique qu'une plus grande intégration régionale se passe. | Entretien UNFPA bureau pays |

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| <ul style="list-style-type: none"> ● S'ils peuvent mobiliser un peu plus de ressources, ce serait pas mal. En général, les problèmes qu'ils abordent sont tellement importants qu'ils nécessitent beaucoup de ressources. Parfois, on a comme l'impression d'un saupoudrage. | Entretien agence multilaterale, Juillet 2021, Benin |
| <ul style="list-style-type: none"> ● Interconnexion et synergie entre différentes composantes MHTF existe conceptuellement mais pas dans la réalité : Est-ce que la revue des MDSR améliore le fonctionnement des SONU ? Ceci impliquerait les actions proposées par les revues sont 1) pertinentes et 2) mises en place, ce qui n'est pas toujours le cas. | Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin |
| <ul style="list-style-type: none"> ● Rôle de leadership joué par UNFPA sur thématique sage-femme ? ABPF a beaucoup appuyé aussi ; leurs interventions sont comparables et se ressemblent. Quel que soit le domaine pris, d'autres partenaires ont aussi appuyé ; les interventions sont liées au mandat du partenaire ; les partenariats sont multiples/multiformes... ça change. ● Ce qui manque, ce sont ressources du gouvernement ● Coordination : UNFPA finance un peu cadres de concertation pour certaines complémentarités dans la mise en œuvre | Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin |
| <ul style="list-style-type: none"> ● Les problèmes sont là et permanents et requièrent des investissements massifs sur un longue période, avec une démarche pérenne ; le fonctionnement par projet est un problème. MHTF travaille sur le long-terme, et c'est bien. Mais dans quelle mesure est-il adapté à nos besoins ? Quel est le rythme de mobilisation ? On apprécie les appuis, mais on voudrait que chaque partenaire s'aligne sur nos priorités. Le Fonds Thématique nous aide beaucoup mais ça ne couvre l'ensemble des déterminants des problèmes et ça fait trente ans qu'on parle de ces problèmes... Il y a eu beaucoup d'investissement, peu d'efficacité, et ce n'est pas par paresse. Il faut interroger le système et la façon dont on mobilise les ressources fait partie du problème. Les aides sont ciblées alors que les problèmes sont ailleurs parfois. | Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin |
| Sudan | |
| <p>Coordination among UN and other partners in emergencies</p> <ul style="list-style-type: none"> ● UNFPA was actively engaged in national and state level emergency preparedness and response coordination platform, including the health cluster. ● SRHR is a standing agenda in the health cluster, and it is chaired by UNFPA. ● The role enables UNFPA to promote SRHR across emergency and humanitarian coordination processes. ● Thus, primary health care departments and relevant counterparts are encouraged to reflect and promote the provision of essential SRHR services. | UNFPA, COVID-19 impact on SRH services and maternal health, 2020, UNFPA, Khartoum, Sudan |
| <p>Coordination with NGO partners</p> <ul style="list-style-type: none"> ● UNFPA is widely acknowledged as the main partner of the FMOH in RH. ● FMOH challenged to address the real needs given the scale but the lack of coordination in all levels compounds this. ● Sometimes UNFPA works with NGOs "away" from the government. The Ministry doesn't have visibility of where NGOs are working which impacts on efforts to do a real needs assessment. ● Better for UNFPA to be more open about their needs assessment and to involve FMOH more on understanding the needs across the different partners. | Interview, RH and MNH Teams, FMOH, Khartoum, Sudan, 1 June 2021 |

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A step change in coordination since 2019

- UNFPA is currently re-shaping the position it plays on coordination in Sudan. “Cannot say there was no coordination under the previous government – level of acceptance of coordination was not much though under the old government. The **new government leadership is much more open to support from donors** and their engagement with coordination.” Four specific coordination processes currently underway:

a. SRHR coordination forum

UNFPA pushing the government to take the lead in re-establishing the Reproductive Health Forum. UNFPA motivated to re-launch an old SRHR coordination forum: UN Agencies, NGOs and others working on SRHR would all join. Early days but seems like it will be reactivated and start to work.

b. RH Standing Agenda

Under UNFPA leadership and takes place within the context of the overarching health cluster which is led by WHO. Active since last year. UNFPA ‘moderates’ the agenda but humanitarian cluster is under WHO. There are also humanitarian working groups in certain states, and UNFPA has been able to lead SRH sub-groups there as well (Darfur etc.).

c. MOU with H6 partners

In discussion with WHO and already signed with UNICEF UNFPA is negotiating a MoU to strengthen coordination matters around SRH including child marriage, FGM, GBV etc. with key H6 partners. Might also then look for triple agency coordination (UNFPA, WHO, UNICEF). UNFPA actively promoting MoU negotiation.

d. Tripartite MOU with UN Partners

Launching an UN-wide process to integrate SRH into all elements of programming. Establishing a cross-UN coordination platform to address SRH in the widest sense. This would be done in the context of the full SRMNCH agenda not just SRH though.

e. Global Ending Preventable Maternal Mortality Initiative (EPMM Initiative) in Sudan

UNFPA requested recently to be the respondent on this global process for Sudan. The request is to develop and submit a report to the global initiative from the platform in Sudan. Not yet active but will require coordination and communication with other partners.

Interview, UNFPA CO, Khartoum, Sudan, 23 June 2021

Coordination

- Although there is an MOU between the two organisations, **most of the joint work is lead and coordinated by the government through technical committees** rather than direct coordination between the two organisations. However, **UNFPA has the “catalytic role supporting the RH programme”**.
- **UNFPA and WHO** together were part of the technical committee, jointly supported the FMOH developing policies, EmONC training manual, post abortion care guidelines and capacity building programmes.

Interview, UN Partner, Khartoum, 9 June 2021,

Interview, UN Partner, Khartoum, 3 June 2021

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| <ul style="list-style-type: none"> ● UNFPA is taking the lead of GBV sector and playing good role doing this and coordinating activities although need more coordination and involvement of WHO. ● However, we are looking for better collaboration and complementarity in the future. | |
| <p>Coordination across partnership for integration of a new area</p> <ul style="list-style-type: none"> ● A policy brief document on cervical cancer was developed and endorsed by FMoH. The document recommends adoption of screening and awareness raising as main interventions of cervical cancer prevention. It also supports the adoption of VIA for the cancer screening and to be implemented at PHC level by PHC care providers who will be trained on this procedure. ● Coordination between stakeholders. A national technical committee for cervical cancer programme was formulated by the General Directorate of PHC at FMoH to oversee the programme development and follow up. ● This committee was formulated from representatives of partners (UN agencies, academic institutions, Donors, Technical individuals and NGOs). The committee oversaw the development process of the policy brief, the situation analysis, the development of national protocols and the training manuals and guidelines. | <p>UNFPA, Prevention of Uterine Cervical Cancer in East Sudan, 2019, UNFPA, Khartoum, Sudan</p> |
| <p>Advocacy, partnership and coordination</p> <ul style="list-style-type: none"> ● These three elements need to be included. Not just about how to use the resources at country level. ● Question about whether the coordination at global and regional level is being done. Given the limited funding, identification of strategic interventions and they approve it. ● However, MHTF as MHTF – are they doing the coordination and partnership and advocacy at higher level not just at country level? | <p>Interview, UNFPA CO, Khartoum, Sudan, 23 June 2021</p> |
| <ul style="list-style-type: none"> ● A change has occurred since the revolution in 2019 and there is more openness to changing laws, implementing laws designed to protect the reproductive rights of women and girls. But progress is “lumpy”. Things move forward and then there is a backlash. Then they move forward again. ● Political negotiation between Islamic powers and the civilian government sometimes come into it: tradition vs. new powers. The government is “not taking all steps – they take some steps but not all”. It is a new government still and facing many challenges. | <p>Interview, UNFPA Partner, Khartoum, 13 June 2021</p> |
| <p>Need to step up coordination</p> <ul style="list-style-type: none"> ● The EmONC Network mapping process was “a huge exercise” using a scientific approach with population and geography and roads all considered as well as other objective factors. It was an important step forward to building a systems strengthening process and very meaningful as a contribution to the delivery of services for maternal health. ● There are many dimensions to it, and they have found ways to enhance the use of the EmONC network even further. It does and will continue to help the country to strategize other investments. ● But now, in addition to EmONC, UNFPA needs to strengthen more advocacy for multi-level coordination. Others are sometimes the coordinators because UNFPA is not always there. Optimise maternal health interventions to maximise the value of Partnership. | <p>Interview, UNFPA CO, Khartoum, Sudan, 23 June 2021</p> |

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Sustained commitment leverages support from partners

- UNFPA funded a technical position to support **the coordination of MPDSR**. A Technical Working Group meets regularly, and all interested/engaged partners are there. One role of the Technical Working Group is to discuss the use of resources to support the advancement of MPDSR (including consultants and their work).
- The **quality of the identified technical staff** are not always what they should be to ensure maximum effectiveness and impact of the programme. In this case, the Technical Working Group, chaired by FMoH, will decide to terminate a contract and seek other candidates.
- This has happened once, “that person and the system under them were not running in an efficient way”. A new consultant was brought on board, agreed by the whole TWG. Their performance will be monitored by the Group and ultimately FMoH will decide what to do.
- In this example, UNFPA provides funding through the FMoH for inputs (consulting fees) that are then discussed and managed at the level of a wider group.

Interview, UNFPA CO Team discussion, Khartoum, 17 June 2021

Partnerships and Coordination

| Technical coordination groups attended/supported by UNFPA | | | |
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| Name of the group | Group Chair | Members | Frequency of meetings |
| EmONC National Committee | PHC Director – FMoH | Representatives of stakeholders; Directors of relevant Departments at FMoH; UN agencies (UNFPA, UNICEF, WHO, ...); Obstetrics and Gynaecology Society; Paediatricians Society | Every two weeks (for specific tasks until accomplishment) |
| Midwifery Committee | Co-chairs: SRH Director FMoH and Dean, Academy of Health Sciences | UNFPA, UNICEF, WHO, Departments of Training, Midwifery and Nursing Council, Midwifery Association representative. | Not regular. |
| Fistula National Task Force | Undersecretary of FMoH | UNFPA, UNICEF, WHO, SRH Department, Curative Medicine Department, Donors, Obstetrics and Gynaecology Society, | Biannual |
| National Technical Committee for Cervical Cancer | MCH Director | UNFPA, UNICEF, WHO, SRH Department, Curative Medicine Department, Donors, Obstetrics and Gynaecology Society, | Quarterly |

UNFPA, List of Maternal Health Functioning Technical Working Groups in Sudan, Khartoum, 2020

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| MDSR National Committee | Undersecretary of FMOH | UNFPA, UNICEF, WHO, SRH Department, Curative Medicine Department, Obstetrics and Gynaecology Society, | Biannual | |
| Togo | | | | |
| <ul style="list-style-type: none"> • Les interventions de l'UNFPA sont toujours alignées sur les priorités nationales. Dans le domaine de la santé, c'est le plan national de développement sanitaire (PNDS 2018-2022) qui est le document de référence. Dans le cadre du PNDS en cours d'exécution, l'UNFPA et l'OMS ont développé conjointement une stratégie focalisée sur la santé de la mère, du nouveau-né, de l'enfant et de l'adolescent. Ce sont ces deux documents qui servent de référentiel pour la programmation des interventions. Comme cela se fait habituellement, ce n'est pas une programmation UNFPA mais UNFPA travaille avec le Ministère de la Santé à identifier les actions prioritaires et sur la base de ressources disponibles, l'UNFPA et le Ministère s'accordent sur les actions qui doivent être implémentées dans les cinq ans. Donc voilà ce qui se passe. L'UNFPA est parfaitement aligné sur les priorités du gouvernement. | | | | UNICEF staff, UNICEF, June 2021, Togo |
| <ul style="list-style-type: none"> • UNFPA est dans le plaidoyer et prend le lead pour certaines interventions (SONU, Pratique Sage-Femme, SDMR, FO) dans le pays à travers le financement par les fonds MHTF, MUSKOKA | | | | UNFPA staff, UNFPA, June 2021, Togo |
| <p>The effectiveness of UNFPA in coordinating efforts:</p> <ul style="list-style-type: none"> • UNFPA assure la coordination de la Plateforme des PTF en SMI/PF • Lead dans certaines interventions : SONU, SDMR, la fistule, Pratique Sage-Femme • UNFPA entretient un dialogue permanent avec le Ministère de la santé pour le recrutement des sages-femmes Finance la reconnaissance des Sage-Femmes méritantes | | | | UNFPA staff, UNFPA, Togo, June 2021 |
| <ul style="list-style-type: none"> • The UNFPA CO in Benin organized virtual sessions with the MoH; particularly, the Family Health department, the regional health departments and a few actors from the private sector, such as the Private Health Sector Platform in Benin. • These sessions contributed to: <ul style="list-style-type: none"> ○ Facilitating the coordination of partners involved and preparing the implementation of the project in the COVID-19 context. ○ Developing COVID-19 protocols and communication campaigns. ○ Providing technical assistance for the planning and the delivery of several workshops (training on infection prevention and control, training on EmONC skills, training on maternal and perinatal deaths surveillance and response, and development of key messages on SRH, COVID-19 and continuation of services). ○ Developing technical documents for the continuation of services and the monitoring of the implementation progress: home visits, outreach strategy, referral strategy, last mile distribution and performance monitoring. | | | | UNFPA and Takeda, Global CSR Progress Report, 2020 |
| Uganda | | | | |

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| <ul style="list-style-type: none"> ● Coordination occurs with UNFPA through the donor group for SRHR TWG, which meets quarterly, although recently it has moved to monthly. The focus since the beginning of the year is to see how to expedite the process of the different SRHR related policies that have stalled over for the last few years. The group developed talking points to share with its leadership (heads of agencies) for use in advocating with very high-level senior people in government. ● There was close coordination with UNFPA during the COVID-19 response. ● There was good coordination with UNFPA when we had fistula funding. ● Regarding technical leadership, “We share is what is it that we can do, and what is it that UNFPA can do. Our counterpart at UNFPA is trying to ensure that UNFPA goes to partners who are qualified and have strong capacity to implement those things – instead of traditionally always going through through the MoH as main IP – which helps them do a bit more implementation out in the field.” UNFPA works more and more through IPs on the ground, they give the IPs the funds, but working with and through the DHOs – which helps them speed up the implementation (because channelling funds through MoH to the districts is very slow). <p>Biggest contributions from UNFPA:</p> <ul style="list-style-type: none"> ● Policy development and contribution to guidelines, updating documents, bringing in short-term consultants to work on that. That work was done almost 2 years ago. With quality-of-care work at national level, UNFPA has also contributed to the Quality-of-Care tools and indicators, they contribute to the design for that, as part of the Q of Care working group – and MCH cluster. In terms of developing tools and guidelines, that is where I can see their advantage coming through for EMONC. ● At the MCH cluster – this is where we get reports from the various TWG, e.g., family planning TWG (update on high strategic issues that have been discussed), e.g., UNFPA played a critical role in hiring consultants to draft the FPCIP 2021-2025, giving feedback and high-level advice on policies and areas that need support. ● Also, (UNFPA contributed to) developing framework for MPDSRT, updating tools for that. Otherwise, they (UNFPA) come and contribute with their technical expertise, looking at some of the issues coming through, but in terms of following up on actions, e.g., PPH which is a huge issue, recently we went ahead with the stakeholders to provide a concept note or framework for revamping the PPH guidelines – technical input/feedback. | <p>Interview, Development partner, Kampala, May 2021</p> |
| <ul style="list-style-type: none"> ● The TWGs are good platforms to share a bit of information – but more deliberate and intentional actions are needed to reach out and coordinate with particular partners, if another partner is doing something similar. UNFPA needs to be very deliberate to reach out to those other partners to reach out - what are the potential overlaps, synergies. How well they do that, it is very difficult to know. Therefore, health development partners/donors who fund UNFPA for similar activities, need to call for a joint meeting with partners engaged in similar activities to ensure coordination. | <p>Interview, Bilateral partner, Kampala, May 2021</p> |
| <ul style="list-style-type: none"> ● MHTF funding for the compilation of the annual MPDSR has been instrumental in advocating and raising awareness about key gaps and issues at national referral hospitals and the level below (referring facilities). The evidence generated through the annual report, and UNFPA advocacy, gained attention of the MoH senior management who established weekly meetings to | <p>Interview, UNFPA Uganda staff, May 2021</p> |

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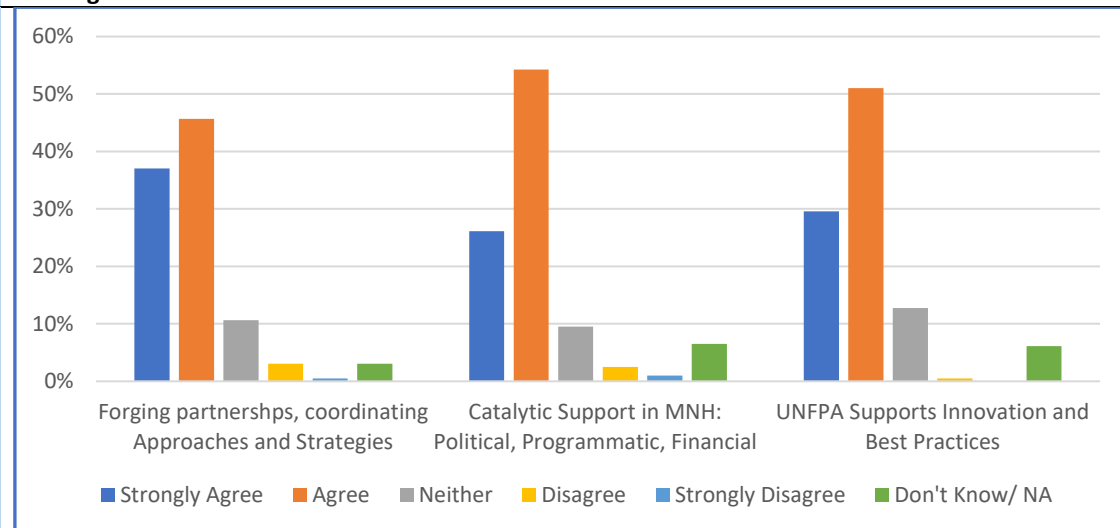
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| <p>discuss gaps/issues and implement/monitor recommendations and action points. MHTF support to the annual MPDSR report is considered catalytic for high level MoH support and action.</p> <ul style="list-style-type: none"> ● “MHTF supports the compilation, analysis and writing of the national MPDSR report every year. That report has been a catalyst to MoH was able to strengthen its leadership and focus on MPDSR. Out of that report, the data shows that most of the maternal deaths are coming from the highly populated districts, and the MoH top management, was able to focus on the national referral hospital – KAWEMPE – just to see what are the issues that cause the maternal deaths there. From having those regular MPDSR meetings every Monday, which involved the Permanent Secretary, the director general of health services, the Director of Curative Services, the Commissioner of Nursing and Midwifery, the Directorate of Health Services of KCCA, partners like UNFPA, UNICEF and USAID. The weekly meeting was also able to attract private players like Stanbic Bank – they supported the platform.” ● UNFPA, with Sida funds (not MHTF) funded “specialist teams” to go from national referral hospitals to the referring hospitals, to give them technical support to solve the issues. ● UNFPA uses Netherland (ANSWER) and Sida (Joint GBV programme) funds to support the district level MPDSR committee meetings. ● Support the Fistula TWG as served as a resource mobilization platform whereby the MoH expresses its needs and gaps and different partners who participate offer financial/technical support to fill those gaps ● After noting that postpartum bleeding/haemorrhage was the biggest cause of death, this year, the “post-partum haemorrhage activity framework” was developed to intervene and try to address the issue and solve the biggest issue of maternal deaths tin the country. | |
| <ul style="list-style-type: none"> ● The implementation modality of GoU/UNFPA country programme is a key to success, as is the presence of UNFPA staff within districts. This enhances the visibility of UNFPA and improved coordination. Strategic engagement with the MoH at senior level produces quick results. ● Coordination at the national level was highly commended, in particular its full support for the full functionality of SRH/HIV coordination platforms at MoH. UNFPA guidance and leadership also supported the functionality of the inter-agency GBV coordination body and National GBV reference group. ● Presence of UNFPA staff in decentralized offices in Karamoja and Eastern regions, Gulu Municipality (Acholi sub-Region and West Nile region) was appreciated and improved the communications between the district government and UNFPA. (However, technical staff in those areas were overstretched in covering wide geographical areas.) | <p>UNFPA Uganda, GOU/UNFPA 8th Country Programme Evaluation Report, 2020</p> |
| <ul style="list-style-type: none"> ● MHTF support for the development of the GIS system was catalytic, as Sida picked it up and funded UNFPA to support its expansion to further districts. ● MHTF funds and advocacy for the compilation of the annual MPDSR report has been catalytic since it gained the interest and support of the MoH, attracted other donors/partners, and Sida funded UNFPA to operationalise MPDSR at the district level. | <p>Interview, MoH Uganda, Kampala, May 2021</p> |

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| <ul style="list-style-type: none"> ● The catalytic fund was able to establish the need to do the social integration of those survivors – and make it a national priority – instead of only a small project. The Clinical Services Department is now taking more leadership – even collaborating with Gender Ministry. UNFPA advocated for this through the revision of national strategy – highlighting it – so that MoH became interested. | |
| <ul style="list-style-type: none"> ● Considering the limited amount of funds under MHTF, the key strategic question for the CO is how to position UNFPA in the future when there are other players with big money. It will depend on how we use catalytic support and how to do well without money to influence discussions and resource mobilization. At the global level, there should be a prioritization on the generation of evidence as that will help to influence others to act and to provide funds. ● UNFPA has capacity to work with the young person – “so we should position ourselves that all we focus on the young person – and when investing in the young person – we improve maternal health, help the government, appreciate maternal health – always though the angle of the young person, the investment of the young person. We also have special advantage in the integration of services.” ● UNFPA contributes significantly to the TWGs, including the RMNCAH investment case and those broader, larger policies as well as the smaller, technical policies. ● Secondment to the government makes a difference; “when we are thin on secondments, we lose out a lot on the politics.” | Interview, UNFPA Uganda staff, Kampala, May 2021 |
| <ul style="list-style-type: none"> ● UNFPA is acknowledged as MH leader within UN in Uganda – “we pick (work) on all the pieces generally, that have to do with MH.” But specifically, for the MHTF – on midwife programming, fistula programming, programming on MPDSR – for those three strands, UNFPA takes the lead generally, in health sector, and at MoH, and within the UN. MHTF funding allows UNFPA to work on upstream level – policy and strategy. At present this work is focused on the revised RMNCAH sharpened plan (i.e. the new GFF investment case). The small funding also allows UNFPA to support service delivery HSS – like midwifery and fistula – training/capacity development, with a focus on sustainable investments for the country, rather than as a project mode. | Interview, UNFPA Uganda staff, Kampala, May 2021 |
| <ul style="list-style-type: none"> ● UNFPA main contribution is the leadership on midwives – contributing towards ensuring that midwives in the countries are increased in numbers. ● UNFPA should take a more strategic approach in terms of working with health facilities to improve with the quality of services. Taking a step-by-step approach in working with facilities. Even UNFPA approach in improving quality of services, it was more “business as usual”- they just trained a few health workers here and there, but it is not structured. | Interview, Bilateral partner, Kampala, May 2021 |
| Zambia | |
| Leveraging partnerships <ul style="list-style-type: none"> ● UNFPA and other partners supported the dissemination of the preliminary Zambia Demographic and Health Survey (ZDHS) results. There have been significant improvements in key national indicators: <ul style="list-style-type: none"> ○ MMR was reduced from 387 to 278 per 100,000 births ○ Per centage of births attended by skilled personnel increased from 64 per cent to 84 per cent | UNFPA Zambia. 2019 Annual Report. 2020. |

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| <ul style="list-style-type: none"> ○ Unmet need for family planning was reduced from 21 per cent to 20 per cent and the use of modern methods increased from 45 per cent to 48 ○ Teenage pregnancy remains an issue and increased from 28.5 per cent to 29.2 per cent. | |
| <p>UNFPA CO perspectives on MHTF as catalytic mechanism:</p> <ul style="list-style-type: none"> ● “It is important for us to direct the little funding we have to strategic investment areas and use evidence to inform these decisions.” Once the MHTF supports these areas, UNFPA works to leverage other investments from government or other partners through the generation of evidence and to support advocacy. UNFPA plays its convening role for planning and budgeting through the national planning process. The government is initiating a process for the next national strategic plan and there is the opportunity to support the process by advocating for high-impact interventions. ● For example, with EmONC, UNFPA can support national or targeted EmONC assessments to identify areas of need or for scalability. “Once something is in the strategic plan, then significant progress follows.” | <p>Interview with UNFPA Zambia, Lusaka. August 2021</p> |
| <ul style="list-style-type: none"> ● “MHTF provides a platform for interaction that enables sharing experiences through the existing platforms to share progress. The other thing I’ve come to understand is that MHTF provides “catalytic” funds, becomes important for us to prioritize and be strategic. What is it that we can do to take the lead and have others participate. Through those processes and understanding of catalytic funding – forges partnerships and bring others to the table. Fistula is the best example. Now the Fistula Foundation is also taking the lead and bring resources to the table and support camps and mentorship. Room for all of us – not encroaching in our space, but additive. This has been helpful to be strategic to the General Nursing Council ... they have tentacles with all the other partners – catalytic fund – helps us support the MOH to support stronger partnerships.” | <p>Interview, UNFPA Zambia national staff. August 2021</p> |
| <ul style="list-style-type: none"> ● Regarding serving as a champion that plays a catalytic function, one challenge is that there are strong coordination mechanisms at the national level (TWG) but these are not so strong at the sub-national level. MHTF has been supporting MPDSR to ensure that the committees should be as strong as the national level. There is a need to strengthen coordination mechanisms at lower levels to better understand problems and inform interventions. | <p>Interview, UNFPA Zambia national staff. August 2021</p> |
| <ul style="list-style-type: none"> ● During Phase III, MHTF funding has been reducing gradually. The reductions have not been felt as much because we have built capacity in regulation and education and have in place the national midwifery strategic plans and curriculum. These activities have reached a sustainable level so that they do not solely depend on UNFPA support. Resources have been mobilized from other programs. When funding was reduced, other partners were identified (CHAI, JHPIEHO), as they also had funding for midwifery. “Instead of just doing in silos, we pooled resources together. All three partners are able to put in something. Stretch little funding as much as possible.” ● “Most impact has been felt in supporting the nurses who want to become midwives. Used to be able to support 50-60 in a go. Cake was cut to support only 10.” | <p>Interview, UNFPA Zambia national staff. August 2021</p> |
| <ul style="list-style-type: none"> ● To a great extent, the MHTF was very influential in the four areas. That is the totality of maternal health. Started it some years ago (decade) and we recorded major milestones – this assisted us in developing the joint program; our work in midwifery and EmONC is very instrumental. MHTF funding is meant to be catalytic; it has led to resource mobilization because of the | <p>Interview, UNFPA Zambia national staff. August 2021</p> |

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| foundation set by this catalytic funding. “It is management – we normally do annual planning, very participatory around the four resources and how they are allocated. What we notice that the funding is released in tranches, comes in very late. What we do at country level, we advance with core resources, to avoid any gaps.” | |
| MoH perspectives on UNFPA role in Zambia <ul style="list-style-type: none"> UNFPA has been consistent. While it supports three provinces, the MoH will include similar approaches in the provinces that UNFPA is not supporting. “We do incorporate others just to increase on numbers and also to make use of available resources that have been given to us.” | Interview, MoH Zambia national staff. August 2021. |
| Other partner perspectives on UNFPA role in Zambia <ul style="list-style-type: none"> To a large extent, they are strong in family planning and supplies – important in Zambia. In the areas of MHTF, on fistula they are probably the only agency that has been pushing the government to ensure that these unfortunate occurrences are addressed. As far as I can see, no one would be raising the issue of fistula. Over time, you noticed that the conversation now includes fistula. Re EmONC, “in my view, UNFPA is making a quick palpable impact in EmONC through its support for building midwifery skills. No other organization is working on midwifery. UNFPA also made a “huge push” on MPDSR, making sure that this is being mainstreamed. There has been a huge change as a result of weekly meetings, regular reviews and surveillance meetings. It is widely acknowledged that putting out the information and showing the numbers results in greater understanding of the problems. The contribution of UNFPA has been “very, very critical. They are the ones that have backstopped the MOH on this issue.” It is a systemic approach, held together by UNFPA, bringing other partners, and assuring the committees are in place. Catalytic: I can say that if you convince the MOH that there is a problem in a particular area of MNH, i.e., fistula, and you see the government itself raising the issue. Very big score. Whichever institution has shifted the mindset through advocacy with MOH and other partners. | Interview, Multilateral organization national staff. August 2021. Kampala. |
| Online survey | |
| Question 12: UNFPA Contribution to Convening Partnerships/Providing Catalytic Support/Supporting Innovation | Online Survey conducted between May and July 2021 |

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| | Strongly Agree | Agree | Neither | Disagree | Strongly Disagree | Do not Know/ NA |
|---|----------------|---------------|---------------|--------------|-------------------|-----------------|
| Forging partnerships, coordinating Approaches and Strategies | 37.06% | 45.69% | 10.66% | 3.05% | 0.51% | 3.05% |
| Catalytic Support in MNH: Political, Programmatic, Financial | 26.13% | 54.27% | 9.55% | 2.51% | 1.01% | 6.53% |
| UNFPA Supports Innovation and Best Practices | 29.59% | 51.02% | 12.76% | 0.51% | 0.00% | 6.12% |

Question 13: Examples of Innovation or Best Practice in MNH Supported by UNFPA

- Portable Mobile Learning System is an innovative approach to improve access to quality training for midwives and health workers in remote low resourced settings with poor infrastructure, erratic electricity, poor internet connectivity and lack of trained tutors, thereby improving the health outcomes in communities which showed good result during the pilot and scale up in selected in service training centres.
- Midwifery-led mentorship program supported by UNFPA
- Increasing access of MH services to teenage pregnant mothers through the Village Health Team system using mobile technology.

Online Survey conducted between May and July 2021

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- Youth engagement in SRH/COVID-19 awareness campaigns ensured that SRH/COVID-19 response plans are sensitive and responsive to youth-specific needs and expectations.
- We have tested the telehealth modality during the COVID-19 situation to ensure that essential RMNCAH services are maintained. This is shared in the Lao MHTF report for 2020.
- Digital training for MCH nurses introduced during COVID19. Chopela Mama Donor: a community-based ride-hailing app being piloted in two provinces in order to provide transport to the nearest maternal health facility for women about to deliver. Infostitula has been built as an easily customizable, mobile App that supports frontline workers for data collection and service delivery. It helps to document and improve every interaction between a fistula patient and her care team across the cycle of care.

Question 17: Looking forward, how can UNFPA strengthen its contribution to MNH and SRHR in your country?

- **Institutional strengthening at both government and CSO levels should be a priority** for establishing true partnerships and ensuring an assertive-cooperative relationship in collaboration with Implementing partners.
- Continue to focus on the **upstream interventions like policy dialogue and advocacy; resource mobilization/ leveraging of resources; increasing MNH visibility** through national events; and strengthening capacity at national level and selected districts based on the LNOB (leave no one behind) approach through training and support with basic equipment.

Question 19: What are your thoughts regarding alternative approaches and ways for the MHTF to deliver high quality technical support within the limitations of its funding and programmatic arrangements?

- MHTF catalytic role: played great role in **facilitating and advocating the issue of SRHR and MNH issues** and lobby government to give priority and allocate more resources in the area of MNH.
- To use more of the integration approach and the fund to be more flexible.

Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments

Indicators:

- **Documented and reported progress on policy processes and political commitment in partner countries**
- **Examples of increased financial commitment from other donor partners for SRHR-MNH efforts in partner countries linked to MHTF advocacy and investments**
- **Examples of trends in financial commitments in countries to MNH**
- **Examples of UNFPA technical or programmatic support to country teams and national and sub-national health authorities that were taken forward by other partners**
- **Assessed technical quality of UNFPA assistance as reported by health authorities and partners**
- **Relevance of UNFPA technical assistance as reported by health authorities, practitioners and implementing partners**
- **Examples of UNFPA engagement in capacity building, which is sustained, relevant and meaningful in monitoring, research, review, and knowledge management**
- **Examples of UNFPA at country level building momentum and supporting tangible policy and programming changes.**

| Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments | |
|--|---|
| Observations | Sources of evidence |
| Global | |
| <ul style="list-style-type: none"> Since equity in access, quality of care and accountability are closely intertwined, the MHTF supports innovative measures and catalytic interventions that integrate the three so that high-burden countries accelerate action and scale up evidence-based innovations for improving MNH. | The MHTF UNFPA, Annual Report 2018, 2019, New York, 2019 |
| <ul style="list-style-type: none"> The UN system and UNFPA response have clearly demonstrated the benefits of the UN Development system reform and coherent UN action⁸. At the global level, UNFPA collaborates with the Executive Office of the UN Secretary General on an ongoing basis to develop and contribute to policy briefs and reports on COVID-19 and gender, human rights, people on the move, children, older persons and mental health. UNFPA also co-authored the health pillar of the UN framework for the immediate socio-economic response to COVID-19 in collaboration with WHO and provided contributions to the social protection and basic services, economic recovery and multilateral collaboration pillars. The positive impacts of UN system collaboration are seen even more clearly at the country level. UNFPA is working more closely than ever with other UN entities as part of country teams under the leadership of empowered resident coordinators to deliver effective and joined-up responses on the health, humanitarian, and socio-economic fronts. | UNFPA, Update on UNFPA response to COVID-19 and strategic, programmatic and operational level impacts, 2020, New York |
| Regional | |
| <ul style="list-style-type: none"> There is a lack of political echo at the regional level. There is not enough investment to engage with ECOWAS health ministers and the ECOWAS Committee of Health Ministers in particular. Muskoka invested in this field in 2018 during the last conference. | UNFPA CO interview, Benin, July 2021 |
| Bangladesh | |
| <ul style="list-style-type: none"> The fistula programme started with MHTF funds but is a bigger programme now and is being implemented following a National Strategy for Fistula which consists of fistula cases identification, referral for repair, rehabilitation of patients and reintegration. This involves beyond the Health Ministry, Ministry of Women and Children's Affairs, Local Government Ministry, Social Welfare Ministry etc. This is a great example of 'catalytic' effect of MHTF. UNFPA current role is providing technical support to DGHS to eliminate fistula. The fistula elimination programme works through a divisional approach in three divisions- Rangpur, Rajshahi and Sylhet. UNFPA support consists of funding training for fistula identification, facilitating referral by supporting transportation and surgery costs for disadvantaged group members, developing capacity of surgeons by facilitating their training, supporting income generation training for rehab of fistula victims. UNFPA has also supported the Obstetrical and Gynaecological Society of Bangladesh in setting up a fistula training institute. There is limited interest among other development partners in this area; UNFPA is therefore advocating with the government for earmarking costs for the fistula programme in an Operational Plan of the sector plan of government. | Interview, Health System Specialist, UNFPA, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> MHTF funds have catalysed many activities and helped UNFPA reach larger results across the spectrum of maternal health, including midwifery, EmONC, and MPDSR. | UNFPA, Bangladesh Country Report, 2018, p 4 |
| Benin | |

Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments

UNFPA Bénin dépenses totales et dépenses MHTF par année 2018-2020 USD – effets démultiplicateurs des co-financements du MHTF alloués aux quatre domaines

La dernière colonne représente une addition des fonds reçus du MHTF et de ceux reçus des Fonds Muskoka, des Fonds Takeda et des fonds propres, qui ont été alloués à des activités relatives aux quatre domaines du MHTF, sur la base de tableaux financiers reçus du bureau pays

| Year | Total UNFPA expenditure USD | MHTF FONDS USD (%) | MHTF + co-funders |
|--------------|-----------------------------|--------------------------|--------------------------|
| 2018 | 4 911 774,16 | 282 128.66 (5.74%) | 615 053,08 (12.52%) |
| 2019 | 5 299 635,95 | 283 980.77 (5.36%) | 385 709,65 (7.28%) |
| 2020 | 4 795 742,09 | 319 804.75 (6.67%) | 856 429,39 (17.86%) |
| Total | 15 007 152.20 | 885 914.18 (5.9%) | 1 857 192 (12.3%) |

Calculs basés sur le tableau financier Vue d'ensemble des programmes et sources de financements SMN et SSR du Bureau UNFPA Benin, rempli par l'UNFPA Benin, Juillet 2021

- La **position catalytique du MHTF peut être représentée par les racines de l'arbre**, qui sont le socle, avec l'équipe innovation et Supplies, qui aident pour les actions sur le Last Mile notamment
- Les **fonds Muskoka sont le tronc** et rajoutent une force financière à travers un cofinancement qui permet d'élargir le modèle d'intervention
- Les **fonds du Canada vont financer le volet VBG dans les SONU** – c'est un projet en préparation
- Les **fonds Banque Mondiale (projet SWEDD** centré sur « Girls empowerment ») inclut un volet santé (10 millions USD) et UNFPA a été sollicité pour l'assistance technique, et est donc en situation d'influencer le design
- Nous poursuivons la **mise à l'échelle avec le secteur privé** (et des compagnies européennes qui comptent financer les SONU).
 - **On peut dire que l'investissement du MHTF a un effet démultiplicateur de 1 à 10**

Entretien, UNFPA bureau pays, Mai 2021, Benin

Exemple de programmes développés par un partenaire bilatéral qui travaille sur les mêmes thématiques que UNFPA, mais qui a peu de relations avec UNFPA :

- **Programme Equité** : Demande de soins dans 8 centres SONU, dont trois sont complets, y compris équipements et infrastructures
- Thème transversal du genre : Mise en place d'un centre de prise en charge de GBV et prévention au niveau communautaire
- Renforcement formation des RH ; centre formation de SONU, appui aux écoles de sage-femme, en mettant l'accent sur le modèle anatomique et pratique
- Travail sur la gouvernance avec la Direction départementale sante dans les zones sanitaires d'intervention en vue d'améliorer la qualité des soins et la collecte de données – **Sur la collecte de données, il y a un gap entre la réalité des outils et ce qui se passe vraiment sur le terrain** : Le remplissage des fiches est un problème (**la digitalisation serait-elle la solution?**), la motivation et le temps manquent souvent, ainsi que la compréhension de l'importance de la collecte d'information et le fait que les mêmes informations doivent être envoyées dans différents endroits
- **Appui a riposte covid : Médicaments et prévention**

Interview, Bilateral Donor, Benin, July 2021

Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments

Mixed performance on catalytic results

- **Programme P@SRIS** – intervient dans deux zones sanitaires et en appui au Ministère de la Santé (appui à la SSR et à l’information sanitaire) sous **deux composantes** : **SSRAJ** pour améliorer la connaissance des droits et **CSE et PF et prévention des grossesses non désirées** et dans les formations sanitaires, pour améliorer **l’infrastructure des maternités** : Renforcement fonctions SONU et Audits (CEHRRUD)
- VBG : Au niveau communautaire et centres de santé en poursuivant une approche multi-acteurs avec des comités qui sensibilisent et cherchent à donner courage aux femmes pour dénoncer et les accompagner
- Formation des polices
- Cancers gynéco – col utérus
- PF : Achat consommables pour assurer gratuité
- Renforcent des SONU et la qualité de l’information sanitaire, incl. améliorer notification des décès maternels,
- **Offre : SONU, maladies non transmissibles...**

Cependant, la coordination et collaboration sont encore faibles : On fait l’effort de les impliquer dans nos activités, mais il y a un problème de de disponibilité ; nous avons eu quelques réunions sur le système d’information sanitaire ; on a participé à un ou deux ateliers qu’ils ont organisés sur le réseau SONU, leur stratégie-phare

Mais on pourrait améliorer la coordination sur la SSR et la collaboration pourrait mieux être structurée. La stratégie phare de UNFPA est le réseau SONU. On n’est pas contre, mais est-ce catalytique ? [Doutes révélés par une mimiques]. Dans un sens, oui car ils proposent une stratégie et c’est rare que le ministère de la santé refuse car UNFPA est perçue comme « une institution d’excellence ». Au ministère, ils essaient de sortir des sentiers battus (y compris pour gérer l’hémorragie post partum). Mais on n’a pas les résultats escomptés.

Interview, Bilateral Donor, Benin, July 2021

- **Peut-être l’UNFPA n’a pas jugé nécessaire d’approcher plus la Banque pour faire la promotion ou la mise à l’échelle des innovations ou leçons apprises. Peut-être qu’ils le font avec d’autres, le ministère, l’OMS mais je n’ai pas senti ça parce que normalement on a des groupes thématiques dans le cadre de la collaboration entre partenaires techniques et financiers mais je n’ai pas à ma connaissance un groupe thématique où on travaille avec par exemple l’UNFPA sur ces domaines-là.**

Banque Mondiale Benin 4 Août 2021

Entretien, donneur bilatérale, Juillet 2021, Benin

- **On collabore beaucoup avec l’UNFPA dans le cadre du projet SWEDD (le projet de la banque) où pratiquement comme dans tous les autres pays, l’UNFPA est recruté pour assister les pays dans les domaines de prédilection de l’UNFPA notamment ce qui est planning familial, la santé de la reproduction, formation des sages-femmes, vraiment tout ce qui est dans le programme actuel de l’UNFPA.**

World Bank, Interview, Benin 4 August 2021

Évaluation de la qualité technique de l’assistance de l’UNFPA telle que rapportée par les autorités sanitaires et les partenaires

- **Par exemple, le projet SWEDD est un bon exemple d’implication de UNFPA pour soutenir le pays avec les fonds de la Banque Mondiale. Je sais qu’ils ont aussi une passerelle avec les Pays-Bas. S’ils peuvent continuer dans ce sens, ce serait bien.**

Entretien avec Multilateral agency, Juillet 2021, Benin

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| Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments | |
| <ul style="list-style-type: none"> ● Je pense que UNFPA fait beaucoup de choses bien. Par exemple, dans le cadre de notre activité, c'est UNFPA qui a créé la mascotte FATI qui représente le prototype de la femme en âge de procréer. Beaucoup d'autres institutions utilisent cette mascotte aujourd'hui, y compris nous à Plan pour la communication dans le domaine de la SSR. Avec cet exemple, je peux dire qu'ils ont vraiment un rôle catalytique. Peut-être qu'eux-mêmes ne se rendent pas compte de l'importance et de l'utilité de ce concept de mascotte mais la plupart des autres acteurs s'y réfèrent aujourd'hui et c'est grâce à UNFPA. Je peux donc dire que UNFPA sait ouvrir certaines voies, quitte à d'autres de savoir les emprunter pour mieux faire. | ONG, Juin 2021, Benin |
| <ul style="list-style-type: none"> ● Au niveau des fistules, il n'y a pas beaucoup de partenaires et UNFPA a bien travaillé dans ce domaine. On a tous vu leur implication dans la formation des médecins, la prise en charges des interventions chirurgicales et la prise en charge des femmes après chirurgie. C'était vraiment bien. Mais j'aurais appris qu'actuellement UNFPA s'est désengagé et c'est la fondation de la première Dame qui appui ça maintenant. | Entretien, donneur bilaterale, Juillet 2021, Benin |
| <ul style="list-style-type: none"> ● Nous avons un partenariat avec l'UNICEF et nous travaillons également avec le fonds belge ; Il y a aussi trois de nos centres de santé qui travaillent avec la Fondation Claudine Talon pour le dépistage du cancer du col de l'utérus ; ABPF aussi travaille avec nos centres de santé pour les campagnes de PF. La contribution de UNFPA est relativement faible si l'on compare aux autres. Cependant, on peut dire dans notre Zone, ils ont été les seuls à nous appuyer pour la prévention de la COVID-19. Ça fait beaucoup de différence | Entretien Personnel de santé du district, Mai 2021, Benin |
| Sudan | |
| Bringing other partners into successful programmes | |
| <ul style="list-style-type: none"> ● EmONC and MPDSR are both programmes started firstly with full support from UNFPA only. ● With progress in those programmes and increased needs for the support, other partners including UNICEF, WHO and others contributed and became increasingly involved (although in many cases on a technical level not as funders). | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |
| <ul style="list-style-type: none"> ● RH Director said this: MDSR programme – about 8 years ago, when the FMOH started the programme, it was MDR (just women), and only supported by UNFPA. As the programme showed results, it became MPDSR it expanded to other donors UNICEF and WHO. | RH Director, FMOH, Khartoum, Sudan, 1 June 2021 |
| <ul style="list-style-type: none"> ● UNFPA funding is “playing a catalytic role supporting CAFA to raise fund from other donors”. CAFA uses funds from UNFPA to demonstrate their capabilities and raise additional funds to extend remit and geography. | Interview, National NGO, Khartoum, 3 June 2021 |
| UNFPA support to the midwifery Gap Analysis kicks off a multi-faceted, multi-year process | |
| <ul style="list-style-type: none"> ● Strengthening the midwifery workforce is a key strategic action for reducing maternal and newborn mortality, according to Sudan's Ten in Five Strategy for SRMNAH. The ICM was invited to facilitate a gap analysis process between October 2017 and August 2018. ● Through a systematic gap analysis process to evaluate the current midwifery education, regulation and association development in Sudan, ICM was able to establish what the gap is between the current status of midwifery and what is required to scale up a skilled, professional midwifery workforce in Sudan. ● The gap analysis approach creates an evidence-based platform for policy decision-making and provides focus on areas for investment as countries develop strategies for strengthening midwifery. | UNFPA, ICM, MoH, Sudan Midwifery Gap Analysis, 2018, UNFPA, Khartoum, Sudan. p.47 |

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| <ul style="list-style-type: none"> ● A workshop to disseminate the results was conducted from 5 – 9 August 2018 in the Rotana Al Salam Hotel in Khartoum. | |
| <p>UNFPA support to the EmONC Network process has been an innovation</p> <ul style="list-style-type: none"> ● EmONC Network – plan made by UNFPA and FMOH to do an assessment of the network. Good results were achieved, and the concept and practicality of the network attracted attention. It was a scientific approach and considered important factors like roads, transport routes, geography and where people actually lived so this created a realistic and workable result in terms of identifying referral networks. The results were sound and there was a lot we could do with it. ● As the assessment progressed, need of more funds was clear and funds were raised from other organisations including WHO, UNICEF who started to contribute once they saw the progress made. More partners have become engaged in this programme, including the African Development Bank. ● The EmONC network continues to exist and is being strengthened currently. There is a process in place now to start the quality improvement and monitoring. The FMOH is still working on this, “we are still working on the network...we are reassessing health centres for the network and to assess the gaps that need to be addressed”. ● In process, a number of technical issues and reassessing needs of selected health facilities and how to cover these needs. No detailed information about the health facilities they selected. “According to what I heard”, there is no plan yet for intervention and assessing these needs. Still planning and re-planning. Already started EmONC support team. Assessment and supervision of EmONC needs – each state in Sudan should have a team. The manual for the training of this team is developed and UNFPA trained one team originally. The FMOH and UNFPA have since worked together to refine the training and teams for other states are scheduled to be trained. The teams will then assess all the facilities in the network in their states. A monitoring process will be put in place. | <p>Interview, RH Team, Interview, RH Team, FMOH, Khartoum, Sudan, 1 June 2021</p> |
| <ul style="list-style-type: none"> ● “It is obviously catalytic, for example, the EmONC and MPDSR are both programmes started firstly with full support from UNFPA only. With the huge progress in those programmes and increased needs for the support, other partners including UNICEF, WHO and others contributed and strongly involved.” | <p>Interview, UN Partner, 9 June 2021, Khartoum</p> |
| <ul style="list-style-type: none"> ● The links between the Humanitarian – Development – Peace nexus offer opportunities to be catalytic. For example, channelling resources for infrastructure renovation/revitalisation to those facilities prioritised in the EmONC network would be one example; Using RH kits to help close gaps in the availability of supplies is another. | <p>Interview, Leadership, UNFPA CO, Khartoum, 17 June 2021</p> |
| <p>Operational innovation: flexible and mobile surgical capacity</p> <ul style="list-style-type: none"> ● In Blue Nile State, the MoH faces difficulties in implementing fistula treatment campaign due to the health condition of the trained surgeon. UNFPA CO in coordination with sub offices in Blue Nile and North Darfur states managed to coordinate with Alfasher fistula centre [where the roaming surgical teams are based] and make the necessary arrangement to bring two fistula surgeons to conduct the campaign in Blue Nile state. The outcome of that is that 23 fistula cases were operated. ● Thus, the aim to build flexible fistula surgical capacity – a very specific skill set – was put into practice such that the surgical team could move around to do batches of fistula surgery without each district having to have its own (scarce) surgery team. | <p>UNFPA, 2020 template for MHTF reporting, 2020, UNFPA, Khartoum, Sudan</p> |

Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments

Digital technology only takes one so far though

- The **use of mobile phones by community midwives** with the view of enhancing the Reproductive Health's Information System in White Nile State, Sudan.
- The idea of granting mobile phones to community midwives emerged at a joint meeting between UNFPA, Kosti and its government counterpart back in 2011. The intention was to resolve the communication problem between community midwives and their supervisors in different districts and hence augment reporting of maternal mortality in White Nile State. The conclusion reached at that meeting was to provide persons involved in the investigation of maternal deaths with **mobile phones to help them carry out their job** in an efficient manner.
- Community midwives issued with mobile phones **ran into a range of technological problems**: in remote villages they had to send their mobiles to the nearest village with electricity service to charge them which could take days. Credit ran out and was not replaced on time. Phones became a valuable resource for the whole village. Because of this, on numerous occasions supervisors could not reach their midwives. Many midwives also experienced problems related to poor network coverage. All in all, although useful, this is **an example of technology not solving the original problem** fully and actually creating many more.

UNFPA, Summary report on the use of mobile phones, UNFPA, Khartoum, 2017, Sudan

Togo

- Grâce aux Fonds français MUSKOKA, l'UNFPA, l'OMS et l'UNICEF apportent un appui à la mise en œuvre du plan stratégique intégré de la santé de la mère, du nouveau-né, de l'Enfant et de l'Adolescent (SMNEA), en particulier dans le domaine des SONU et la SDMNR, deux interventions sur lesquelles le fonds MHTF de l'UNFPA a joué un rôle catalytique faisant du Bureau UNFPA le lead au Togo sur la question des SONU et sa mise en œuvre un modèle dans la sous-région malgré les résultats encore insatisfaisants.
- **Le fonds MHTF apporte un appui non négligeable dans la promotion de la pratique sage-femme.** Les progrès en cours portent entre autres, sur une intégration des SONU dans le plan de santé maternelle et néonatale avec un cadre programmatique au point : le réseau SONU défini et revisité en 2018, un monitoring régulier qui analyse la situation et fournit des données sur la disponibilité et la qualité des soins, et qui fait avec la SDMNR, l'éventail régulier des dysfonctionnements en cours dans le système de soins, causes des décès maternel ; un effort d'intégration du paquet de la santé
- Même si une complémentarité/synergie avec les Fonds MUSKOKA sur le programme UNFPA s'annonce improbable, du fait que ces fonds seront considérablement cette année, tout comme pour les précédents plans le financement sous MHTF restera complémentaire des initiatives du Gouvernement togolais et d'autres partenaires techniques et financiers, au plan national. Ces initiatives sont, entre autres: l'offre de services par la Clinique Mobile à laquelle contribue le Gouvernement à travers le Programme d'Urgence pour le Développement Communautaire (PUDC) en cours; les appuis de l'Agence Française de Développement et de la GIZ/KFZ dans le renforcement de l'offre de service PF et les SONU et l'appui de l'Union européenne dans le domaine de la SRAJ.
- Les interventions de l'UNFPA ont boosté les actions en faveur de la mère et de l'enfant avec pour entrer principale les SONU (cartographie des SONU). Les actions menées après la cartographie ont mis un focus sur les SONU.

UNFPA, MHTF Request Proposal 2019-2022, 2019

UNFPA, MHTF Request Proposal 2019-2022, 2019

MoH staff, June 2021, Togo

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| Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments | |
| <ul style="list-style-type: none"> ● Opportunités: Projet MUSKOKA/ AFD dans la région des plateaux et maritime (mise aux normes dans les SONU; poursuite des actions de l'UNFPA dans ces zones, notamment le renforcement des compétences des prestataires, l'équipement des structures en SONU, la réhabilitation voire la construction des maternités pour répondre aux normes). Un projet en train de prendre corps dans la région de la Kara avec un financement de la coopération financière allemande qui vise le renforcement des SONU de la région de la Kara (infrastructure et réhabilitation pour leur permettre de répondre aux normes ; renforcement des compétences des prestataires) Défis Appui régionalisé, non étendu | |
| Uganda | |
| <p>MHTF as catalytic for resource mobilization</p> <ul style="list-style-type: none"> ● There is a clear link between the MHTF funded activities (see other documents and interview notes) and the Sida-funded MNH activities, which is an indication that MHTF investments in the four technical areas had catalytic effects, in terms of mobilising additional funds and being integrated into this new Sida-funded GBV programme, for example: ● Sponsorship for education of midwives and bonding to hard-to-reach districts ● Scaling up of the GIS system for registration and licencing of midwives – Sida-funded an expansion to additional 15 districts. ● Procurement of MNH kits for health facilities. <ul style="list-style-type: none"> ● UNFPA mobilized more resources from Sida under the UN Joint Programme on GBV and the EU-Spotlight initiative to support 18 Fistula repair camps by 14 Hospitals and social reintegration. | <p>Interview, Bilateral donor, Kampala, May 2021</p> |
| <p>MHTF as catalyst for programming</p> <ul style="list-style-type: none"> ● UNFPA supported the GIS to monitor and track midwives and their distribution in country. “We use it to support the distribution of midwives. We are still in the roll-out stages and have reached 30 districts. Sida has come on board to facilitate and further scale-up. MHTF is catalytic: the platform was created, and then we used it to mobilize funds from other donors.” MHTF used to fund a dedicated UNFPA staff to support the midwifery department of MoH in the past; now, UNFPA supports capacity development of MoH staff working in the department. <p>Other examples of catalytic funding:</p> <ul style="list-style-type: none"> ● MHTF funding for fistula social reintegration: EU Spotlight (GBV programme) and Sida-funded Joint GBV Programme with UN Women includes fistula activities. ● MPDSR: MHTF funds and advocacy for the implementing the annual MPDSR report has sparked support and commitment from the MoH and has attracted other donors/partners, including through Sida-funded UNFPA activities to operationalise MPDSR at the district level. UNFPA and WHO have played a role in advocating for the MPDSR process and making the evidence about the root causes of maternal and neonatal deaths available. MPDSR is now led by the senior management of the MoH. UNICEF and USAID came on board with technical and financial support later on (although it is not clear exactly what year). Sida is funding UNFPA to strengthen district MPDSR committees. ● As a result of the weekly MPDSR meetings, a national PPH Action Framework was developed to address the weak blood supply chain system. UNFPA is supporting the revision of the list of life-saving drugs, i.e. shifting from oxytocin (which requires a cold chain) as first line drug to other heat stable drugs. | <p>Interview, MoH National staff, May 2021</p> |

Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments

- “When you look at Adolescent Health, you see a unique perspective or approach, of carrying out “outreaches” – we have an issue of access in this country, so the catalytic funding of UNFPA helps us get those services to the adolescents, refugees and hosting populations, to the most vulnerable. The health facilities are not able to do outreaches, so the UNFPA funds have helped us do that.”

Interview, MoH staff, Kampala, May 2021

Zambia

Reported progress on policy and political commitments in Zambia

- In 2018, UNFPA in Zambia continued to support sub-national level programmes aimed at improving EmONC, midwifery services, as well as prevention and repair of obstetric fistula, among other crucial needs to ensure “no woman dies giving life”. Specific actions included the following:
 - Through **technical and financial support from UNFPA, the MoH finalized and disseminated its first RMNCAH&N Communications and Advocacy Strategy**. This strategy is a key milestone for the country as it seeks to increase coverage as well as utilization of RMNCAH&N services.
 - UNFPA supported the **development and dissemination of the National Human Resources for Health Strategic Plan (2018 - 2024)**, which details key approaches for addressing human resource for health challenges in the country (including skilled birth attendants), as well as the critical role of community health workers towards improving availability of services.
 - UNFPA supported the **development of Nursing and Midwifery Protocols, whose implementation is expected to facilitate improved quality of care in health facilities across the country**, towards reducing maternal mortality and morbidity. (p.11)
- “As one of the 46 countries supported by the global “UNFPA Supplies”, **UNFPA in Zambia sustained its collaborations with the Government of Zambia in operationalizing the National Family Planning Scale-Up Plan (2013- 2020)**, which aims to increase the national contraceptive prevalence rate from 33% to 58% by the year 2020. Specific actions by UNFPA and the Government of Zambia included the following:
 - Development of a short to medium term concept note for increased domestic financing for family planning commodities
 - UNFPA’s procurement of an estimated 50% of targeted commodities for the public sector, among others.
 - Government’s budgetary allocation to family planning commodities was increased by 50%; from an average of USD 1million in the preceding four years to USD 1.6million in 2018.” (p.7)

UNFPA Zambia. 2018 Annual Report. 2019.

- Results reported for 2018 include:
 - 1,000 maternal deaths averted due to contraceptive use
 - **80 midwives trained in skilled birth attendance; 177 health care providers acquired skills and knowledge in EmONC**
 - **220 women with obstetric fistula repaired**
 - **203 health facilities improved capacities to provide EmONC services**
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UNFPA Zambia. 2018 Annual Report. 2019.

Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments

- In 2020, the **Q2 monitoring report** included “not reported” as the status for the following milestones:

| Milestone | Q2 Target |
|---|-----------|
| Number of nurses enrolled in midwifery training with UNFPA support | 10 |
| Number of health care providers with capacity to conduct quality MPDSR processes in UNFPA supported provinces | 20 |
| Number of obstetric fistula survivors repaired and followed up for post-operative care | 40 |
| Number of health care providers with knowledge and skills in the management of SGBV | 85 |
| Number of health care providers with capacity to provide adolescent friendly integrated SRH/HIV/GBV services | 85 |
| Number of health care providers with knowledge and skills to provide quality Comprehensive Abortion Care services | 25 |
| Number of health care providers oriented on Respectful Maternity Care guidelines | 30 |
| Number of public health facilities providing adolescent-friendly integrated SRH services in UNFPA supported districts | 20 |
| Number of adolescents and young people reached with SRH information and services | 120,000 |

UNFPA Zambia. 2020 Q2 Monitoring – Zambia. 2020.

- UNFPA is very supportive to MoH in terms of policy. It supports us to review and update policies; they need to be reviewed and updated every five years. UNFPA supported the review and revision of the family planning Costed Implementation Plan which expired last year and helped come up with a new plan for the next five years. UNFPA supported it through a consultancy with very short notice.
- “One of the biggest policy areas we need to work on is RH policy (which had been delayed because of COVID-19). UNFPA has been very supportive – have not yet started, but they are ready to support it. We did the terms of reference. Now elections are over, we can start running with that.”

Interview, MoH Zambia national staff. August 2021.

Reported challenges in achieving results through UNFPA assistance:

- The GRZ faced a “severely constrained fiscal space” which affected its ability to sustain the financing of key social services, including the SRH programme. “This led to supported provinces receiving less than 30 per cent of expected annual grants

UNFPA Zambia. 2019 Annual Report. 2020.


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| Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments | |
| <p>from government, making it difficult to achieve desired results in SRH and sustain initial investment from development partners. For example, limited funding to fistula management compromised investments into mobilization, follow-up, and social re-integration of fistula clients. In addition, despite the recognized shortage of skilled human resource, the identified gaps could not be addressed due to lack of authority to recruit additional critical workers such as midwives and doctors. During the year, there was high government reliance on limited resources from development partners to support routine health system processes such as performance review meetings.” (p. 3)</p> <ul style="list-style-type: none"> • Several changes were made at Ministerial, Permanent Secretary and Director levels in most line Ministries and provinces where the CO operates which resulted in some implementation delays. • “The changes to implementing partners’ funding modalities from direct cash transfer to direct payment, specific to a particular restricted funding grant, and the change in strategic focus of the DFID supported RMNCAH&N programme resulted in limited and delayed investment in expanding the number of health facilities providing quality EmONC services. This could not be addressed within the year under consideration, and interventions will in 2020 be scaled up to broader geographical coverage focusing on family planning and adolescent health. (p.3) | |
| <p>UNFPA CO perspectives on results from catalytic programming</p> <ul style="list-style-type: none"> • “MHTF has been very beneficial and has gone a long way; catalytic. The provinces have benefitted. Provinces can only hold a MPDSR meeting because of MHTF. When government has been constrained, the funding has been very useful. Right now, the institutions that support midwifery training still feel the effect of the resources that have been available. But what can investments in policy do if there are no resources for training, capacity and equipment?” | <p>Interview, UNFPA Zambia staff. August 2021.</p> |
| <ul style="list-style-type: none"> • “Although the funds are limited/catalytic, we are constrained by the many priorities. The areas of focus remain critical in Zambia. If the funding was increased, it would make a great impact. Flexibility would be good, but do not want to spread ourselves too thin. We cannot even adequately fund one area in full. Would like the flexibility to direct perhaps to one or two areas, if relevant in country. The funding is very important to us and to other countries – advocate for it to be increased. Would not like to see the funding concentrated to fewer countries, as it would mean that funding might get cut from places that really need it.” | <p>Interview, UNFPA Zambia staff. August 2021.</p> |
| <ul style="list-style-type: none"> • “MHTF has been very, very helpful. Without Dfid we will be limping. Core resources will be very difficult to locate funding for maternal health. Family planning is very key – family planning commodities are critical, and this will take priority. Really depending on the MHTF and core funds to support this programme.” | <p>Interview, UNFPA Zambia staff. August 2021.</p> |
| <ul style="list-style-type: none"> • “It is important for us to direct the little funding we have to strategic investment areas; use the evidence we have to use the funds.” One example involves supporting evidence through national or targeted EmONC assessments to identify areas of need or for scalability. • Another area that is important is supporting advocacy and convening – playing a convening role for planning, budgeting “That area requires better guidance and some work to more strategically support national planning processes. The government is initiating a process for the next national health strategic plan. There is the opportunity for us to support the | <p>Interview, UNFPA Zambia staff. August 2021.</p> |

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| national planning process, we know the unit cost of interventions for high-impact interventions. Once that appears in the strategic plan, then we can see significant progress in the EmONC.” | |
| Online survey | |
| <p>Question 17: Looking forward, how can UNFPA strengthen its contribution to MNH and SRHR in your country?</p> <ul style="list-style-type: none"> • Through continuous advocacy, lobbying on universal SRHR at global and national level. • Through effective community engagement, partnership and high-level political advocacy and influence • Continue to focus on the upstream interventions like policy dialogue and advocacy; resource mobilization/ leveraging of resources; increasing MNH visibility through national events; and strengthening capacity at national level and selected districts based on the LNOB approach through training and support with basic equipment. More effort should also be put on supporting pre-service training instead of in-service training that is inherently more expensive. • UNFPA to enhance its convening role on MNH and SRHR • Prioritize and focus on a small number of interventions that are impactful and most needed as opposed to multiple small initiatives that do not translate to any impact for the recipients. • By developing policies, strategies and protocols of the SRHR • Institutional strengthening at both government and CSO levels should be a priority for establishing true partnerships and ensuring an assertive-cooperative relationship in collaboration with IPs. | Online Survey conducted between May and July 2021 |
| Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries | |
| Indicators: | |
| <ul style="list-style-type: none"> • Documented and reported progress by UNFPA in developing and implementing a knowledge sharing strategy and approach that was systematically disseminated at global and regional levels • Examples of regional level knowledge sharing, identification of innovations and good practices • Examples of UNFPA approaches to gathering evidence about best practices and developing ideas and strategies to take these to new countries or settings • Examples of UNFPA support to better monitoring and review and to more knowledge sharing among country teams and national and sub-national health authorities • Reported timeliness of UNFPA technical assistance • Assessed technical quality of UNFPA assistance as reported by health authorities and partners • Relevance of UNFPA technical assistance as reported by health authorities, practitioners and implementing partners • Examples of UNFPA engagement in capacity building, which is sustained, relevant and meaningful in monitoring, research, review and knowledge management • Examples of UNFPA at global and regional level building momentum and supporting sustained roll out of innovation or best practices • Examples of knowledge development, management, and communication especially around good practices in the MHTF programme. | |
| Observations | Sources of evidence |
| Global | |

| Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries | |
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| <ul style="list-style-type: none"> ● An important methodology of the MHTF is connecting countries to technical skills through partnerships and this has been incredibly effective in the case of midwifery (ICM) and EmONC (GIS Unit at the University of Geneva). | Interview, UNFPA HQ, February 2021 |
| <ul style="list-style-type: none"> ● A rising number of institutional births has generated an increased focus on the quality of care for women and their newborns in many MHTF-supported countries. In 2018, Burkina Faso, Burundi, Niger and Togo started systematically documenting the case fatality rate from direct obstetric complications in EmONC facilities, gaps in midwives, stock-outs of life-saving commodities, the number of maternal deaths notified, and the numbers reviewed. They also focused on mentorship for both pre-service and in-service midwives as well as capacity-building for teachers. | The MHTF UNFPA, Annual Report 2018, 2019, UNFPA, New York |
| <ul style="list-style-type: none"> ● A critical challenge that most governments and development partners face is finding solutions to reach marginalized populations in rural areas and providing them with quality MNH services. To surmount this challenge, UNFPA launched a portable mobile learning system, a rural training solution for health workers in 2016 to train midwives and health workers in key skills to combat the most prevalent causes of maternal and newborn mortality. This project was made possible through a generous grant by the Government of Denmark to UNFPA to find innovative ideas and solutions to address sexual and reproductive health issues. The mobile learning system is an innovative, simple, mobile, and cost-effective solution for the training of health-workers in low resource settings that provides a manifold return on investment. ● It is highly suitable for remote rural settings where there are challenges of infrastructure, lack of electricity, poor internet connectivity, and lack of trained tutors. ● Mobile learning system helped trained 2,525 health workers (nurses, midwives, midwifery students, community health workers) and over 500 non-healthcare workers in a short span of nine months (April-December 2016), bringing the total to about 3,040 beneficiaries. | UNFPA, Portable Mobile Learning System Brochure, New York, USA |
| <ul style="list-style-type: none"> ● The success of the mobile learning system in training tutors in remote provinces in Ethiopia as well as Tanzania in 2016 and 2017 prompted Rwanda to launch a similar initiative in its most remote and poorest district, Rutsiro. As a result, the Government has proposed a nationwide scale-up over the next several years. ● Other innovative programmes like Helping Mothers Survive and Helping Babies Breathe also continue to expand in collaboration with Laerdal Global Health and Jhpiego (the Program for International Education in Gynaecology and Obstetrics affiliated with Johns Hopkins University). UNFPA has joined the ICM-led and Laerdal-funded 50,000 Happy Birthdays project in Ethiopia, Malawi, Rwanda, Tanzania and Zambia. | The MHTF UNFPA, Annual Report 2018, 2019, UNFPA, New York |
| <ul style="list-style-type: none"> ● UNFPA could probably look around at the current global trends and start shifting away from directing knowledge and input to countries towards a more interactive, partnership-based model of working. The four technical areas are very needed, but the format may not be best suited given the way development is evolving and the growing focus on partnerships, south-south learning etc. | Interview, global health partner, July 2021 |
| <ul style="list-style-type: none"> ● This is a great project and could make a difference in many contexts, but it needs more visibility and engagement across UNFPA internally. ● It is a wonderful use of digitalisation. | Interview Global Technical Partner, September 2021 |

| Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries | |
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| <ul style="list-style-type: none"> ● MHTF produces knowledge products that have impact such as the State of the World’s Midwives report. Ministries of Health come to UNFPA when they want knowledge (not money!). ● A maternal health strategy under consideration and we are looking at how to work on more integration with SRHR especially within UNFPA itself. ● Looking at how to support/ interact with climate change, migration, population and other critical forces. ● Spill-over from MHTF to maternal health beyond the 32 partner countries. | Interview, UNFPA Global Staff, March 2021 |
| Regional | |
| <ul style="list-style-type: none"> ● Regional offices are not as empowered as they could be. Need to have more responsibility, a greater role, more accountability too. They could be so important to pushing agendas out at country level, supporting country programmes etc. | Interview, UNFPA Global Staff, March 2021 |
| <ul style="list-style-type: none"> ● My experience from within the region where I work is not always welcomed, I do not think. I do not feel my voice is heard among others both here and in HQ. Somehow, we need more synergy among our four areas and also more consideration of or focus on the community. We do not really engage at the community level yet that is where opinions about health are formed, and decisions are taken. We could do it though – midwives are at the centre of everything and UNFPA is leading on midwifery. | Interview, UNFPA Staff, September 2021 |
| Bangladesh | |
| <ul style="list-style-type: none"> ● UNFPA catalysed the spread of midwifery education by developing the framework of the programme in the early days. The programme then ‘took off like fire’, and now there are three to four education programmes in the country. | International Midwifery Specialist, UNFPA, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● The above examples (enabling policy and regulatory environment for midwifery education, strengthening the midwifery education programme and strengthening the capacity of midwifery associations) are all catalytic; UNFPA sowed the seeds and helped to nurture those with the government and then the government adopted all these practices and spread them across the country. | Midwifery Officer, Nursing and Midwifery, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● The examples cited under midwifery and MNH and SRHR integration exemplify the catalytic role of UNFPA. It has a successful record of working in partnership with development partners, national and international technical agencies and the national government and its directorate. | Adviser, FCDO, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● UNFPA effect has been indeed catalytic. Its technical support helped to develop a robust education programme; being a recipient of several funding streams helped UNFPA to keep the midwifery development programme on track through different funding cycles, appointment of technical mentors in government facilities helped to empower midwives in those facilities and establish their roles effectively in delivery care. | Adviser, FCDO, Dhaka, Bangladesh, June 2021 |
| Benin | |
| <ul style="list-style-type: none"> ● L’innovation est un travail méthodique et structurant au Benin, une méthode de travail. | Entretien UNFPA bureau pays, Benin, Juin 2021 |

Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries

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|  <p>• Empowered people • Resilient communities • Sustainable solutions • Accelerated results ...</p> <p>Local makers/ PPE including Facemasks</p> <p>UNFPA INNOVATION</p> <p>AR/VR for midwifery</p> <p>Drones to deliver to the last mile</p> | |
| <p>Covid 19 : Un accélérateur de changements. Décision, avec ministère de la sante, d'utiliser les fonds COVID-19 de manière stratégique, en visant les effets à moyen terme.</p> <ul style="list-style-type: none"> • Le MHTF est utilisé comme un laboratoire pour prendre le temps de déployer des innovations qui répondent à des goulets d'étranglement (enseignement ; sang ; masques). • Dès Mars, déploiement de masques et sanitisers; il a fallu trouver une solution immédiate, sans attendre l'aide internationale, vu que les échanges étaient bloqués. • D'où solutions locales et innovation: production de masques produits localement en Mars : prototype de masque en tissu qui a passe tous les tests (avec l'appui d'un comité scientifique piloté par des experts). Production de masse des Mars, à l'attention des mères essentiellement. Ceci a aussi permis de créer des emplois et répondre au choc économique du COVID-19. • Visières produites localement avec imprimante 3D en avril. Solution de lavages de main. | <p>Entretien, UNFPA bureau pays, Mai 2021, Benin</p> |
| <ul style="list-style-type: none"> • Enseignement des sages-femmes de Parakou : Utilisation de méthodes d'enseignement utilisant des outils de réalité virtuelle/réalité augmentée, pour combler le manque de cours pratiques/méthode des tableaux noirs et pallier aux faiblesses de l'enseignement, et mieux comprendre la réalité du métier ; • Drones pour apporter les produits de première nécessité (une étude menée a mis en avant la non-disponibilité du sang comme un obstacle majeur) – processus commencé en décembre 2019 et quand Covid-19 est arrivé, opportunité a été créé pour expérimenter les drones dans deux Zones sanitaires | <p>Entretien, UNFPA bureau pays, Mai 2021, Benin</p> |
| <p>Phases de développement des innovations</p> <ul style="list-style-type: none"> • Atelier avec sages-femmes en 2019 pour identifier les difficultés qu'elles rencontrent dans leur métier. Elles ont émis l'idée de réduire la chaîne d'approvisionnement des produits médicamenteux intrants : Poches de sang n'arrivent pas ou trop tard. C'est pourquoi on a décidé d'utiliser des drones pour réduire le temps d'approvisionnement. • On a aussi créé une plateforme pour que les sages-femmes soient en relation, pour améliorer leurs connaissances en dehors de l'école • La Fondation Takeda, dès 2019 a apporté les fonds pour ces innovations • Etude de faisabilité sur drones : 21 maternités : Maternités dimensionnées (géo, temps...) • Trois tests de livraison ont été effectués avec succès | <p>Entretien, UNFPA bureau pays, Mai 2021, Benin</p> |

Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries

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| <ul style="list-style-type: none"> ● De jeunes logisticiens ont été impliqués – 12 ont été formés par partenaires pour piloter les drones, en partenariat avec le programme Supplies, qui travaille avec le ministère de la santé, car les drones sont un moyen de renforcement de la chaîne d’approvisionnement | |
| <ul style="list-style-type: none"> ● Prototypage : Lancement officiel avec ministère et partenaire Innovation ● D’autres livraisons doivent se faire d’ici fin Juillet avec les 3 drones ● Le concept existe au Botswana (UNFPA), Ghana (pas UNFPA) et Rwanda (pas UNFPA) ● L’expérience a été capitalisée avec ESARO – drone pour améliorer la chaîne d’approvisionnement ● La réflexion est maintenant de savoir comment passer à l’échelle ; elle est conduite entre UNFPA/la Ministère de la Santé/et la compagnie partenaire ● Capitalisation d’une App qui met médecins en réseaux (FB des médecins) : sages-femmes inscrites qui demandent conseil aux médecins ou échangent entre elles, UNFPA peut poster info, contact avec d’autres pays. Cela crée une dynamique chez sage-femme pour chercher de l’information | <p>Entretien, UNFPA bureau pays, Mai 2021, Benin</p> |
| <ul style="list-style-type: none"> ● Describe planned activities and anticipated challenges during the next reporting period. Please include any proposed revisions to the objectives, activities, and/or timeline in your proposal. In Benin: Strengthening of the last mile supply chain for family planning and EmONC products through the use of drones, support for supportive supervision and quarterly EmONC monitoring, providing connectivity for 49 targeted EmONC facilities and 6 departmental health directorates avec video conference systems, enhancing the use of mobile applications for data collection in real time and training of health workers for its usage, involving 25 young logisticians in the project intervention areas, and enhancing screening capacities for the protection of health workers and proper triage at the district level. | <p>UNFPA and Takeda, Ensuring Access to Quality Maternal and Newborn Healthcare During the COVID-19 Pandemic: Global CSR Progress Report, 2020, UNFPA, New York</p> |
| <p>Sudan</p> | |
| <p>Catalytic investments</p> <ul style="list-style-type: none"> ● Three examples of genuinely catalytic investment are offered. ● (i) Strategic guidance of the MHTF around the EmONC assessment. This was a good example of funds being used to provide evidence and strategic orientation for the future of the programme which lies at the heart of the mandate of UNFPA. MHTF investment enabled training and mobilization of capacity in the system and the country to generate evidence. The resulting evidence enabled the mobilization of partners including the country government to do more on MNH through EmONC because it identified a clear pathway for something specific to be done and then set out the steps to get there. The EmONC network, now reaching a point of operability, influences resource allocation decisions and helps improve value for money. ● (ii) More than this, however, the identification of the EmONC network – ostensibly to improve MNH outcomes – has already served additional needs. For example, following the floods of 2020, more than USD 4 million was made available to UNFPA Sudan to support the rehabilitation of health infrastructure in affected states. Because the EmONC Network development process had clearly identified agreed referral facilities at BEmONC and CEmONC level, rehabilitation was directed to these facilities first and the resources were used to acquire equipment and furniture and specialist facilities (theatre, sluice, etc) needed to raise the quality of services at these facilities. | <p>Interview, RH team, UNFPA CO, Khartoum, Sudan, 23 June 2021</p> |

| Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries | |
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| <ul style="list-style-type: none"> • (iii) in a separate example, MHTF engagement in advocating for and supporting the development of a fistula strategy resulted in a widened scope of interventions beyond just repair to include prevention and recovery and reintegration. Other funding was mobilised to widen coverage – 30% of all repairs are financed now by MHTF but the rest are financed by others including FMOH itself and other resources made available from the UNFPA CO budget. | |
| <p>MDR became the MDSR and is now the MPDSR</p> <ul style="list-style-type: none"> • The long history of UNFPA support to maternal death notification and review suggests that it has attracted other partners into the process over time. • As the MPDSR has become more capable of identifying and recording maternal deaths, it has attracted other partners including UNICEF and WHO. | <p>Interview and group discussion, FMOH, RH Team, Khartoum, Sudan, 1 June 2021</p> |
| Togo | |
| <ul style="list-style-type: none"> • The programme will be implemented in synergy with other United Nations organizations in the spirit of "Delivering as One". Joint projects in the field of statistics to monitor the implementation of the universal periodic review recommendations are under consideration. A joint project is planned in collaboration with UNICEF and UNDP to empower adolescent girls, promote their rights to sexual and reproductive health and protect them against harmful practices. Joint resource mobilization initiatives will also be conducted with technical and financial partners and the private sector. The resource mobilization and partnership plan that underpins this country programme will be implemented and revised periodically. | <p>United Nations, Agenda for the second regular session 2018, 2018</p> |
| Uganda | |
| <ul style="list-style-type: none"> • Refer to evidence laid out under evaluation question 1-4 for examples of technical assistance, capacity building and knowledge exchange/best practices. | |
| Zambia | |
| <p>UNFPA perspectives on use of evidence for programming</p> <ul style="list-style-type: none"> • As a result of evidence and research conducted, including assessments, the programme has evolved over time to implement more targeted interventions. “Once you do the assessment, you have better evidence. We actually assisted in HSS and contributed to improved quality of care through capacity-building for health service providers. Also assisted in promotion of how child marriage and early pregnancies lead to fistula. We integrate service strengthening with the community component. For example, fistula: we have noticed from our own research that fistula was occurring among young mothers/adolescent girls because of delays in getting appropriate care and decisions to seek care which resulted in prolonged labor. We noticed this happening because of child marriage/early marriage. This message was integrated during our commemoration during fistula day, bring community leaders/members to create awareness around dangers of child marriage and for ordinary mothers to inform re mothers’ shelters; assist to monitor mothers/SMAGs. | <p>Interview, UNFPA Zambia staff. August 2021.</p> |
| <p>Collaboration with Maternity Foundation to pilot Safe Delivery App</p> <ul style="list-style-type: none"> • UNFPA collaborated with the Maternity Foundation to support the MoH to introduce the Safe Delivery App that can be loaded on any smartphone and used offline. The app is designed to increase skills to manage pregnancy-related complications. | <p>UNFPA Zambia. 2019 Annual Report. 2020.</p> |

Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries

Twenty-five (25) midwives and doctors acquired knowledge and skills as trainer on the use of the Safe Delivery App to support the roll-out across the country.

- UNFPA reported that effective collaboration with the Maternity Foundation, the Zambia Library for Persons with Visual Impairment and the Fistula Foundation led to achievement of results that could not have been achieved alone.

- **The Safe Delivery App was developed by the Maternity Foundation as a free application for use by midwives and other skilled health personnel to provide direct access to evidence-based and up-to-date clinical guidelines for BEmONC services.** The app contains easy-to-understand animated instruction videos, action cards and drug lists and **can serve as a training tool in both pre- and in-service training as well as an on-the-job reference tool for health workers, trainers and supervisors.** There are training exercises/modules in the following topics: infection prevention, post-abortion care, hypertension, normal labor and birth, active management of third stage labor, prolonged labor, postpartum haemorrhage, manual removal of placenta, maternal sepsis, neonatal resuscitation, newborn management, and low birth weight.

The Maternity Foundation.
Accessed from:
<https://www.maternity.dk/safe-delivery-app/>.

Online survey

Question 19: Experience sharing and linking the challenged countries with country with best practices in similar context to provide practical technical guidance to improve the maternal health portfolio.

- Experience sharing and linking the challenged countries with country with best practices in similar context to provide practical technical guidance to improve the maternal health portfolio.

Area of Investigation 8: MHTF governance and management

Evaluation Question 8: To what extent have the MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme? Specifically, how have these facilitated: (i) resource mobilization for the MHTF; (ii) the breaking of silos among UNFPA programmes; (iii) the integration of MNH within country programmes; and (iv) effective oversight and guidance by the MHTF Advisory Committee?

Sub-questions:

- To what extent has the MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme including through influencing the overall strategic directions and efforts of UNFPA in MNH and broader SRHR more broadly?
- To what extent have MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and contributed to MHTF resource mobilization?
- To what extent have MHTF management mechanisms and internal coordination processes contributed to breaking silos among UNFPA programmes at global and national levels including strengthening integration of MNH within country programmes?

| Evaluation criteria | <i>Effectiveness, efficiency, coordination</i> |
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| Rationale | The MHTF is one of several thematic funds in UNFPA. Focused on maternal health, it is also one of the few global maternal health funds (others include the GFF) but is distinguished in part by its specific focus on four technical areas (midwifery, EmONC, MPDSR and fistula) in 32 countries. Resources are generally declining as global MNH is less prioritised in the SDGs. Coordination, management, leadership, and efficiency are critical in order to ensure the aims of the fund are met and maximum impact from available resources is realised. |

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver

Indicators:

- MHTF programme guidance which incorporates required adjustments/improvements in SRHR policies and programmes communicated to other branches
- MHTF staff/secretariat participation in forums and meetings at global, regional and CO to develop broader SRHR policies and to integrate services
- MHTF results frameworks and programme reports incorporate linkages to SRHR policies and programmes
- UNFPA staff in other branches engaged in SRHR report MHTF input and influence on policies and programmes
- Minutes and report of intra-UNFPA coordinating bodies note cross influence of MHTF and SRHR on policies and programmes
- Examples of mechanisms to support coordination, strategic direction, forward momentum, and overall performance at global, regional and country levels
- MHTF investments and activities contributed to strengthening coordination with other UNFPA thematic programmes
- Country offices approached thematic areas holistically, in line with countries' own systems (integration at the country level)
- Examples of efforts to integrate across the SRMNCAH agenda at global, regional and country level
- MHTF support enabled increasingly effective performance of the programme, breaking down barriers to programmatic silos and supporting increased efficiency
- Examples of the MHTF role and activities in relation to regional knowledge and management approaches

| Observations | Sources of evidence |
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| Global | |
| <ul style="list-style-type: none"> UNFPA “has been a good partner to us” and the programme has “gone very well in our view” | Interview, Global donor partner, 3 September 2021 |

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver

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| <ul style="list-style-type: none"> ● Once the multi-year workplan is finalized and approved by the country representative, the Regional Director, the Chief of the Sexual and Reproductive Health Branch, the Chief of the Non-Core Funds Management Unit and the Director of the Technical Division, it will be transmitted to the unit for managing the yearly disbursement of funds. Disbursement will depend on the yearly review of progress made. ● The MHTF complements UNFPA core resources by enhancing the evidence base in MNH, promoting best practices, and backing integration across the continuum of sexual and reproductive health care from prevention to care. MHTF strategic interventions, close monitoring of results and contribution to the MNH research agenda have influenced the UNFPA Strategic Plan (2018-2021) and contribute to strategic investments of other UNFPA resources (core and non-core), increasing effectiveness, efficiency and scale. ● The MHTF will continue to be an active member of technical working groups such as EPMM, ENAP, the Quality of Care Network, and the EmONC group. These advance the MNH agenda in terms of new evidence, new/refined indicators, and operational guidance and tools to support programme implementation. The implementation expertise of the MHTF contributes to informing indicators and operational guidance. ● In phase III, MHTF-supported countries will develop a multi-year workplan (for 2019 to 2022) based on the MHTF strategic interventions and result indicators that best fit their context. This approach, which is different from the annual workplans developed in previous phases, aims to support county offices to develop a strategic vision on MNH, in line with national strategies and plans, towards specific, realistic and measurable milestones. It will increase efficiency and reduce planning and monitoring requirements. The multi-year country workplans will be developed in the second and third quarters of 2018 and implemented from January 2019. This process will be supported by the MHTF team at headquarters and MHTF focal points at the regional level. | <p>The MHTF UNFPA, Business Plan Phase III (2018-2022), New York, 2018</p> |
| <ul style="list-style-type: none"> ● The most difficult part of the partnership – the amount of reporting, far more than any of our funders. Quarterly reporting. In the grand scheme of things, we charge UNFPA a much smaller indirect. Have to justify it every year, but with the added reporting requirements, it is so out of balance. | <p>Interview, global non-government policy partner, September 2021</p> |
| <ul style="list-style-type: none"> ● Implementation skills – need good political skills to build country level commitments. The weight of commitment needs to be at the country level. Health systems is not just technical work – given the loss of donors to the MNH area, need to maximise impact for gender, equity, arguing for the big picture but focusing on the country as the locus of development and action. | <p>Interview, global technical partner, September 2021</p> |
| <ul style="list-style-type: none"> ● We support MHTF because it focuses on MNH but with links to SRHR and is really the only partnership that does that. MNH is hard to deliver and to demonstrate results: complex area, massive numbers/ needs, technically demanding and communication is challenging. ● The contribution of the MHTF to the strategic plan is not always clear. What does it mean to be strategic – or catalytic – in that context for example? ● We do struggle to justify it though because this is core business for UNFPA, and we also give core funding to UNFPA so we would prefer to see more core funding going to maternal health and SRHR integration. ● We would like to see more evidence of core funds being channelled to priorities at country level. | <p>Interview, Global Funding Partner, June 2021</p> |

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| Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver | |
| <ul style="list-style-type: none"> ● There are limited resources available through the MHTF and these are spread over too many countries. If a CO can mobilise local resources or use core funds, that is helpful. I am concerned that with such low levels of investment, expectations by governments are higher than can be delivered by UNFPA. ● Funds should mainly focus on prevention, strengthening quality and a strong referral system. | Interview, Global Funding Partner, July 2021 |
| <ul style="list-style-type: none"> ● Despite a multi-year MoU with UNFPA, budget for the next year is always developed and agreed very late in the year. This makes planning hard. We have multi-year contracts with other partners, and this is easier for us to plan our resources (we are in demand). It would be more efficient and probably more effective to have a longer-term agreement with UNFPA. ● The partnership has been very good from our side. Things have moved slowly, and we are not the only partners on the team; governments lead and for many reasons, programmes can be slow. COVID-19 has not helped. ● It was evident to us when new leadership arrived in UNFPA both at the MHTF level and the branch level. It has made a big difference to the commitment of the programme. | Interview Global Technical Partner, September 2021 |
| Regional | |
| <p>Online Survey Question 19: What are your thoughts regarding alternative approaches and ways for the MHTF to deliver high quality technical support within the limitations of its funding and programmatic arrangements?</p> <ul style="list-style-type: none"> ● The programme now has a very strong regional presence for the RH and maternal health which is excellent. The CO is well supported and can benefit from the technical inputs from that level. | Online Survey open question (May to July 2021) |
| Bangladesh | |
| <ul style="list-style-type: none"> ● UNFPA is an effective leader because it is aware of field situation and is practical. - It also has the ability to respond quickly as it has more flexibility than other agencies. - UNFPA team is very committed. | Director, Directorate General of Family Planning, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● MHTF “has done a good job” in enabling UNFPA to take on new interventions and focusing on areas of need (e.g., midwifery, cervical cancer screening, fistula programme which all started with MHTF funding). It is sometimes prescriptive though, e.g., asking for cutting back on number of EmONC centres to enable MHTF to focus on fewer sectors. MHTF also does not allow countries to figure out what problem to address; Instead, it directly recommends what interventions to set up (e.g., EmONC network). | Midwifery Officer, Nursing and Midwifery, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● UNFPA regularly reviews progress of various project reports and makes adjustment as necessary. In addition, UNFPA monitoring team makes field visits which identifies problems and weaknesses and again changes are made to address those weaknesses/ problems. Similarly, if the need for any input related to the projects is identified by the government, UNFPA responds quickly and efficiently. | Midwifery Officer, Nursing and Midwifery, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● Like other UN agencies, UNFPA priorities are based on five-year Country Priority Assistance Plans developed through a rigorous evidence based, consultative process. However, it has the flexibility to take on board activities based on need of the hour, as evidenced by the COVID-19 related activities it supported and still supports. It also responds to un-anticipated need for support by the Government- e.g., playing a mediation role to bring together the two arms of the MoH (Directorate General of Health and Directorate General of Family Planning) in working together for the implementation of National PPH and Eclampsia Strategy. | Adviser, Donor Partner, Dhaka, Bangladesh, June 2021 |

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| Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver | |
| <ul style="list-style-type: none"> MHTF is a good example of enhancing collaboration among various actors and enhancing coordination. For example, the midwifery programme has brought together a number of development partners, government and UN agencies. The mechanism also fosters interlinkages between programmes on the ground, e.g., midwifery and fistula programme, for which there is no other coordination mechanism. MHTF funds can not only initiate small programmes which catalyse bigger, more sustainable programmes (midwifery, fistula, MPDSR), but can also be used to sensitise target groups on contemporary issues, e.g., initial days of midwifery programme when MHTF helped to produce the paperwork needed to mainstream midwifery education and deploy staff. | Health System Specialist, UNFPA, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> UNFPA works very well coordinating and managing several large important agencies including the MoH and its directorates, as well as multilaterals and NGOs. | Project Director, NGO, Dhaka, Bangladesh, June 2021 |
| Benin | |
| Définition des priorités / ventilation budgétaire au sein du MHTF n'est pas optimale | |
| <ul style="list-style-type: none"> L'avantage comparatif du Fonds Thématique est qu'il est la colonne vertébrale du financement du fonds de UNFPA Comment peut-on l'utiliser avec plus d'efficacité ? [...]. Les défis liés au MHTF sont : « L'ajustement » : Si le problème est le même, on ne peut aborder le problème de la même manière dans chaque région ; le fonds est flexible et nous permet d'aborder les 4 domaines mais on devrait pouvoir décider dans quel ordre on fait quoi. Répartition entre les domaines : 30% SONU/50% MDSR/20 % sage-femme: On est obligé de rester dans ces enveloppes, mais on est « un peu coincé » pour définir nos priorités car la ventilation des pourcentages est définie par le FNUAP. Une recommandation serait de revoir l'allocation des ressources chaque année, en tenant compte des besoins | Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin |
| <ul style="list-style-type: none"> Planification de manière conjointe ces 4 dernières années. La ventilation entre les différentes composantes est discutée avec le siège et les médecins coordonnateurs de Zone. Le siège décide de la planification pluriannuelle et le contenu de ce qui est mobilisé définit la durée du financement (1, 2 ou 3 ans). La ventilation des ressources non-thématiques se fait sur la base des priorités nationales. | Entretien, UNFPA bureau pays, Mai 2021, Benin |
| <ul style="list-style-type: none"> Au Benin : La priorité est donnée aux SONU, en tant que défini par unfpa. Une des difficultés des SONU est que le personnel change en permanence, ce qui empêche que le personnel ait le niveau suffisant et toutes les fonctions SONU. Il faudrait miser plus et allouer plus de ressources sur la pratique de sage-femme – mise à niveau/formation continue sont nécessaires. | Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin |
| <ul style="list-style-type: none"> Le reproche principal que nous faisons à UNFPA, c'est que les fonds n'arrivent pas à temps. Les PTA sont signés mais pour décaisser, on attend 2 mois. Donc pour des activités prévues sur 3 mois, nous n'avons qu'un seul mois pour exécuter. Ce qui crée des difficultés et beaucoup de pression au niveau des équipes. Si on pouvait avoir les ressources d'une année entière et planifier en conséquence, ce serait beaucoup plus facile. « Comment dépenser l'argent de 3 mois en un seul mois et fournir un rapport d'exécution cohérent ? ». | Entretien ONG, Juin 2021, Benin |
| <ul style="list-style-type: none"> La procédure de gestion financière, de mise à disposition des ressources, doit être améliorée : Décaissement trimestriel et compte-rendu rend les choses difficiles – on avance par saccades (comme si on avait des « gavages périodiques alors que les besoins sont quotidiens »). Mais l'interaction est bonne en matière de souplesse en planification des activités. | Entretien, Ministère de la Santé, Cotonou, Mai 2021, Bénin |
| Sudan | |

| Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver | |
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| <p>COVID-19 led to reallocation of resources</p> <ul style="list-style-type: none"> ● COVID-19 had significant implications for programme continuity. Most of the planned activities were revised to accommodate the COVID-19 prevention. ● Focus was still SRH-MNH services despite COVID-19: increased awareness about how to deliver essential services despite the pandemic. | <p>UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>UNFPA management valued by partners</p> <ul style="list-style-type: none"> ● CAFA had been working with UNFPA on SRHR service delivery since 2014. ● Working with UNFPA compared with other partners is well coordinated with clear monitoring and evaluation plans, they are very committed and respectful to partners. ● There is some weakness in coordination between localities and state level in addition to coordination between different directorates in the SMOH especially when conducting integrated services | <p>Interview, National NGO, Khartoum, 3 June 2021</p> |
| <p>Flexible and responsive resources</p> <ul style="list-style-type: none"> ● UNFPA is different as RH is its main mandate and primary focus. ● UNFPA is more flexible than many partners and is usually able to provide technical support in a range of areas. ● UNFPA provides support by transferring resources to the FMOH and then we can hire our own contractors. We consult with UNFPA, but the leadership remains with the FMOH. | <p>Interview, RH Team, FMOH, Khartoum, Sudan, 1 June 2021</p> |
| <p>Resources</p> <ul style="list-style-type: none"> ● Would like more money but technical resources are also resources and “we need these as well”. ● Financial, human, infrastructure are the three main types of resources, but technical resources are also important and relevant. | <p>Interview, Leadership, UNFPA CO, Khartoum, Sudan 23 June 2021</p> |
| <p>Reported facilitating factors included HQ support</p> <ul style="list-style-type: none"> ● CO received strong technical guidance and facilitation on several interventions from UNFPA HQs and from ASRO. This has been instrumental to achieving the expected outcome from the EmONC assessment and EmONC development processes. ● Working closely and jointly with HQs and Regional SRH advisors and experts enhances adoption of more strategic interventions and facilitates the adoption and implementation of results and decisions. | <p>UNFPA, MHTF Annual Report Sudan 2018, 2019, UNFPA, Khartoum, Sudan. p.3.</p> |
| <p>...but HQ also hindered progress</p> <ul style="list-style-type: none"> ● Late signature of work plans and the start of a new programme cycle delayed the start of implementation until the second quarter of the year. | <p>UNFPA, MHTF Annual Report Sudan 2018, 2019, UNFPA, Khartoum, Sudan</p> |
| <p>Country Programme outputs 2020 are articulated clearly</p> <ul style="list-style-type: none"> ● Output 1: Strengthened capacities of health ministries and civil society partners at federal and priority states level to ensure access to high-quality SRH services, including in humanitarian settings ● Output 2: Enhanced capacities to develop and implement policies, including financial protection mechanisms that prioritize access to information and services for SRH and reproductive rights for those furthest behind, including in humanitarian settings | <p>UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020</p> |

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| <ul style="list-style-type: none"> ● Output 3: Strengthened capacities to provide high-quality, integrated information and services for family planning, comprehensive maternal health, STIs and HIV, as well as information and services that are responsive to emergencies and fragile contexts ● Output 4: Strengthened capacities of the health workforce, especially those of midwives, in health management and clinical skills for high-quality and integrated SRH services, including in humanitarian settings ● Output 5: Improved domestic accountability mechanisms for SRH and reproductive rights through the involvement of communities and health-system stakeholders at all levels | |
| <p>Lessons learned</p> <ul style="list-style-type: none"> ● How processes, successes, including unexpected results and challenges inform future planning ● The frequent changes in MoH structure along with phasing out of the OB-GYN registrars had a significant impact on the MDSR system functionality ● Technical assistance to support MoH to restore the system must be maintained in 2021 ● Interventions involving field work should start towards the beginning of the year as they require more preparations. ● The delay in receiving the first tranche late in Q1, had a significant impact on the implementation rate which was further impacted by the COVID-19 pandemic. ● Impact of lessons learned on the 2021 work plan ● Receiving the first tranche in January to enable early kick off for the activities to contribute positively to achieving the desired results. | UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020 |
| <p>Resource flows interrupted</p> <ul style="list-style-type: none"> ● The CO ceiling was set to be USD 450,000. However, the third disbursement was not fully received; the CO was notified and adjusted the implementation accordingly. Loss of funds given the limited budget has impact on outcomes. | UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020 |
| <p>UNFPA investment in core skills for surgeons (fistula)</p> <ul style="list-style-type: none"> ● Need for technical support in 2021 to improve the capacity of midwifery associations through experience sharing between associations at states particularly in resource mobilization and advocacy ● Improve the technical capacity of staff at fistula centres through external training and linking fistula centres with other training centres for more experience sharing ● Enabled sufficient capacity to be built in Sudan. Foreign surgeons not needed to run fistula camps as sufficient country-based teams. ● Needs to be continued and nurtured, however. | UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020 |
| <p>Internal linkages between HQ and CO</p> <ul style="list-style-type: none"> ● Question from country team member: does the UNFPA CO sufficiently maximise opportunities created by the MHTF? “MHTF is so helpful, and HQ is providing great technical support through MHTF which should continue. It makes follow ups for the long term and this is what is needed for the targeted countries. It also pushes for strategic interventions. It provides opportunity for experience sharing.” | Comments, UNFPA CO staff, Khartoum, Sudan, 23 June 2021 |

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| <ul style="list-style-type: none"> ● MHTF needs more funds, which HQ should lead on and at CO level, UNFPA needs to capitalize on MHTF investments. | |
| <p>Challenges include:</p> <ul style="list-style-type: none"> ● Weak health system ● Limited human resources and rapid turnover, poor retention ● Need to strengthen the supply chain ● Build community demand for services ● Weak concept of patient-centred culture. | <p>Interview, RH Team, FMOH, Khartoum, Sudan, 1 June 2021</p> |
| <p>Some MHTF support channelled to a sub-set of states</p> <ul style="list-style-type: none"> ● UNFPA focused its midwifery support on some of the States (Kassala, North Kordofan, Gedarif, White Nile, Blue Nile, East Darfur, North Darfur, South Darfur, West Darfur, and Central Darfur). | <p>Review of programme activities, UNFPA CO, Sudan, 22 June 2021</p> |
| <p>Other elements of MHTF support are national in scope</p> <ul style="list-style-type: none"> ● The midwifery programme is mainly a national level intervention in relation to standards, guidelines and preparation of the new curriculum. The development of the EmONC network is national in scope as well. | <p>Review of programme activities, UNFPA CO, Sudan, 22 June 2021</p> |
| <ul style="list-style-type: none"> ● Within UNFPA CO, in 2019, all the sub-units including MNH, Emergencies, RH Supplies, MHTF etc were all linked together into a single unit within the CO. The three technical coordinators now work closely on a daily basis, and this helps manage gaps. For example, they use their access to RH Kits to ensure the gaps in Sudan are covered to some extent and this is facilitated by the new integrated structure in the CO. | <p>Interview, Leadership, UNFPA CO, Khartoum, 17 June 2021</p> |
| Togo | |
| <ul style="list-style-type: none"> ● The programme will be implemented in synergy with other United Nations organizations in the spirit of "Delivering as One". Joint projects in the field of statistics to monitor the implementation of the universal periodic review recommendations are under consideration. ● A joint project is planned in collaboration with UNICEF and UNDP to empower adolescent girls, promote their rights to sexual and reproductive health and protect them against harmful practices. ● Joint resource mobilization initiatives will also be conducted with technical and financial partners and the private sector. The resource mobilization and partnership plan that underpins this country programme will be implemented and revised periodically. | <p>United Nations, Agenda for the second regular session 2018, 2018</p> |
| <ul style="list-style-type: none"> ● UNFPA est dans le plaidoyer et prend le lead pour certaines interventions (SONU, Pratique Sage-Femme, SDMR, FO) dans le pays à travers le financement par les fonds MHTF, MUSKOKA | <p>UNFPA staff, UNFPA, June 2021, Togo</p> |
| <p>Les rôles spécifiques et la valeur ajoutée de l'UNFPA:</p> <ul style="list-style-type: none"> ● Coordination des partenaires en santé maternelle ● UNFPA assure la coordination de la Plateforme des PTF en SMI/PF ● Leadership sur les questions SONU, Pratique Sage-Femme, FO et SDMR. | <p>UNFPA staff, UNFPA, Togo, June 2021</p> |
| National: Uganda | |

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver

- The collaboration and coordination between the UNFPA CO, GoU and other cooperating partners is important and is aided by the implementation modality of the GoU/UNFPA and the presence of UNFPA staff within districts. Operating decentralized field offices was considered by stakeholders as a key strategy for fostering visibility, technical assistance and enhancing the functions of coordination, sub- national level partnerships and quality assurance. An area of improvement is to expand coverage in relation to the number of district and ensure that staffing is adequate.
- UNFPA has a solid financial management and tracking system to facilitate programmatic and financial accountability. However, there are delays requisition of funds by IPs and disbursement by UNFPA, affecting the timely and quality of implementation activities.
- There need to be accountability mechanisms integrating multisector programming and for integrating gender equality, rights and gender transformative programming within existing GoU programmes. For example, the CO should engage the MoH for the strengthening the MPDSR committees at district level, including the strengthening of community level intelligence/surveillance for maternal deaths; for encouraging pregnancy mapping and tracking by VHTs; and for strengthening the accountability/feedback systems for health at community and national level.

**UNFPA Uganda, GOU/UNFPA
8th Country Programme
Evaluation Report, 2020**

Development partner perspectives

- The role of UNFPA as a convening power is appreciated, along with its ability to gather multiple stakeholders from government, NGO/CSOs, donors, academia and private institutions to participate in a national conference focusing on the integration of SRHR, GBV and HIV in February 2021.

**Interview, Bilateral donor,
Kampala. May 2021**

Coordination strengthening needed

- The national level TWGs work well, e.g., the SRHR TWG but also MPDSR, but there is a **need to strengthen coordination** at SHO level. “But EMONC and midwifery, it is not clear – we recognize they do not have so much funding – but the activities still do not come across clearly. The **collaboration** is left at the Maternal Child Health Cluster TWG under the MoH national even – we share date etc., but we do not specifically know how UNFPA is touching on EMONC and midwifery. But it is not clear what UNFPA is doing in this.
- Midwifery as a technical area – we do not discuss that – I do not even know what is under midwifery – I know we discuss at the celebration of the national day – so it is not clear what the work is under midwifery – the regulation etc. Maybe that is discussed in other platforms – not for the MCH cluster.
- But **EMONC should be discussed at this MCH cluster. We do not really talk about EMONC at the MHC** – we talk about the different sub-areas. When we discuss the EMONC issues, two years ago, UNFPA was very involved in the updating of the guidelines, with WHO and other stakeholders – now we just discuss issues under the EMONC – and there is no link, unclear what UNFPA is doing at the district level.”
- Having UNFPA funds go through MoH level and then down to the local level – it was very different for partners, because it was very difficult to bring the DHO to the table. One of the biggest challenges we had with UNFPA giving resources through MoH and then to the districts – there was little transparency.

**Interview, Development
partner, Kampala, May 2021**

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver

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| <ul style="list-style-type: none"> ● The support to district level coordination is an area to focus on –coordination at the global level is going well but does not translate down to DHO led coordination yet. | |
| <ul style="list-style-type: none"> ● A challenge is the UNFPA “business as usual” where strategic thinking is not happening within the team. The problem is that UNFPA is used to “swinging off their technical mandate”, and technical partnership with government, and they go more into implementation/operation mode, but they need to balance implementation with strategy as they remain a very strong partner who can influence the MoH. UNFPA gets so much into their implementation mode, instead of maintaining their role as technical advisors and technical partner of MoH. Striking a balance is very important, what is the value addition of UNFPA as compared to CSO. As more donors start to fund them bilaterally, they get swamped into implementing projects, meet donor requirements etc. instead of keep focusing on what they really need to do at the national level. ● Another observation, which has been discussed with CO management, is that within UNFPA internally, the different technical expertise, is not being pulled together. “When you go to the field level, you do not see the interconnectedness between components, integration between the components, because they are quite siloed, to really implement a comprehensive system strengthening support. If I look at health facility level, where we support GBV, FP, MNCH etc. – you would expect the team to sit down together, to see how they can work together, support the full package – liking data management commodities etc.” ● The many different IPs that implement components of the project do not coordinate well together. “There is not an appreciation of the integration we are talking about. Having different IPs is not the problem, because having a partner that can cover all areas is not easy, but the UNFPA field coordinator must be strong, to ensure very strong integration. If the team internally at UNFPA is not able to do this, then everything falls apart. This appreciation needs to come from UNFPA internally. ● The good news is UNFPA has responded to this feedback, and we have received a new strategy which we are reviewing. They have looked critically on how integration within the programme and organisation can be improved. But at least, it has started a reflection process within UNFPA on how to improve some of these issues.” ● UNFPA manages through a very “output based management process, we implement XX activity – but do not think about strategy and how the components fit with each other.” They do output-based partnership management. | <p>Interview, Bilateral donor, Kampala, May 2021</p> |
| <p>Government partner perspectives</p> <ul style="list-style-type: none"> ● “What makes UNFPA unique is that they have tried to support many levels of what I call the comprehensive package of care – UNFPA is involved in supporting policy and guidelines development, they support dissemination – and they have operational support to the districts, either through CHOs or CSOs, they get money to the districts through them. They also are one of the leading partners in Maternal, Newborn and Child Health – and support the MoH across the continuum of care.” | <p>Interview, MoH official, Kampala, May 2021</p> |
| <ul style="list-style-type: none"> ● Challenges with implementation and support include delayed transfer of funds and direct funding of schools without adequate notification to the MoES to enable them to monitor and provide support. While the district selects the midwifery candidates, the MoES should be informed about the process for monitoring purposes. “Some things remain at national level, e.g., for diploma students, there is another process. For them, we use joint admission board; that process is managed at the national level.” ● There is an inter-ministerial meeting between MoH and MoES to coordinate health education and training. It would be good to have the UNFPA consultant midwife participate because it is a strategic-level meeting that covers issues of human resources, | <p>Interview, MoES official. Kampala. May 2021.</p> |

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| budgeting, collaboration, and clinical attachment, internships, etc.” She is currently not participating in those meetings, but she should.” | |
| <p>Regarding coordination, with other UN agencies:</p> <ul style="list-style-type: none"> ● UNICEF: There is strong coordination between UNICEF and UNFPA in terms of coordinating activities and avoiding overlap in MNH support in the West Nile and Acholi sub-regions where both are active. Since UNFPA received funds from Netherland for the ANSWER programme late 2020 (which includes significant funds for MNH), the need to coordinate activities in those sub-regions have become important. Since beginning of 2021, UNICEF and UNFPA meets quarterly to coordinate activities at the national level and want to extend these coordination meetings to the sub-regional level. When they have funding for the same type of activities (e.g. EMONC support), they make sure they do not provide the same kind of support in the same health facilities, but rather “divide the facilities/communities up geographically” between them. For example, for MPDSR, UNICEF, UNFPA and WHO collaborates to support the districts MPDSR committees – each organization covers a different sub-region/geographical area, so they do not overlap. ● WHO is responsible for guidelines; therefore, there is a lot of coordination with WHO at the national level through various TWG, i.e., MCH, and also adolescent health. At the operational level, UNICEF, UNFPA and WHO collaborate in the district of Hoima for MPDSR. to see how to improve MPDSR in that region covering 3 districts: UNICEF supports Arua in West Nile and UNFPA covers Hoima (humanitarian setting) and neighbouring districts. Because Hoima regional referral hospital oversees all other districts in terms of standards and technical capacity, they can support other districts in those areas. | Interview, MoH national staff, Kampala, May 2021 |
| <p>UNFPA comparative advantage</p> <ul style="list-style-type: none"> ● Regarding the relative comparative advantage of UNFPA in Uganda, “I think we really stand out in midwifery because I do not see any other agency that can talk about midwifery the way UNFPA can. We also stand out in MPDSR, and fistula and we give credit to MHTF to enable us to contribute in that.” ● There is a comparative advantage working both at policy and service level and making sure there are strong linkages between the two levels. | Interview, UNFPA Uganda national staff, Kampala, May 2021 |
| <p>There are three key advantages that UNFPA has:</p> <ol style="list-style-type: none"> 1. The UNFPA integration approach – linking MNCH with family planning and GBV. UNFPA has made good progress with integration – it is a steady progress. 2. The Field Support Unit at the CO level, and field presence (through the seven field offices ensures a strong anchoring of UNFPA at the district level. That is the biggest advantage regarding UNFPA here in Uganda. 3. UNFPA ability to implement SRHR in humanitarian settings. It is 95 per cent part of the refugee response. | Interview, UNFPA Uganda national staff, Kampala, May 2021 |
| <p>UNFPA Coordination with other UN agencies</p> <ul style="list-style-type: none"> ● UNFPA has not used the catalytic fund to sit down with UNICEF and WHO to have joint coordinated support to the MoH, as is supposed to be done under the new UN framework, where you have leads that are corresponding to the implementation of the implementation of the framework. That is the new way of working. “Maternal health is one of the easiest for UNICEF, WHO and UNFPA senior management teams to sit down to discuss and coordinate. But we have not done that here at the country level. I | Interview, UNFPA Uganda national staff, Kampala, May 2021 |

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver

would go as far as to say we “missed funding” because we were not up to that level of coordination... how to be complementary between UNFPA, UNICEF, and WHO.”

- “We have not done enough in fistula; it has been piecemeal. We have not done enough fistula repairs for at least two years – perhaps it was due to USAID stepping out. But I would have imagined that among the HDP donors someone would pick it up.”
- On coordination of refugee/humanitarian response – and government stewardship: The **leadership and accountability of the government – it needs to be strengthened and supported**. It is a national excuse: That the refugee influx in itself is a huge pressure on the health system. The political agenda that was hacked. There is a need to push the government to ensure stewardship. The MoH must be at the centre. Although there are structures area already in place –more resources go through strengthening them.

Opportunities/challenges with MHTF as a mechanism

- **MHTF has “pre-determined” interventions** – if you want to introduce a new intervention, you have to drop one of the pre-determined interventions; but they are also important, and it is difficult for us to drop one of them. There is a lack of flexibility.
- “The MHTF funds are very limited, so hard to drop one intervention. The funds are limited, the expectations are high, and the problem which we are trying to address is so huge and complex.”
- The challenge is that follow-up activities are often needed to ensure that activities supported by MHTF are implemented effectively and this is not always possible with small amounts of catalytic funding.
- **Midwife should/will be at the centre of achieving our goals for maternal health**. The support to midwifery in terms of regulation, association etc. – UNFPA is unique in that area; not many partners are supporting midwifery.
- MHTF raised the profile of the four technical areas. Now you see many programmes and developing partners, supporting these areas, so it has been really catalytic. That has been the main achievement of MHTF. It contributes to the overall strategy, because the global strategy is ending preventable maternal deaths and comorbidities e.g., fistula. So, it aligns every well with global and country level... the new 9th country programme focuses on ending preventable deaths.
- To reduce maternal mortality rates, there must be access to EmONC care services. There has to be demand – that is the second output. Women and girls must be empowered to demand and use those services. That is very critical. UNFPA is investing a lot in leadership and governance, at all levels, from national to facility and community. It is cross-cutting, for this to happen, there must be an enabling policy and legal environment, and also HSS is cross-cutting because it affects service delivery.
- “However, if we could add something, the MHTF should add a community component. MPDSR links with communities, but other three areas are supply/facility based. Most of our communities are rural – and you really need to build community structures and systems – and link them to health facilities. Community systems for accountability etc. If you only focus on supply/facility level, and if you do not work on community level, you will not succeed. E.g., when you look at the first delay (decision), and second (referral) – they contribute to 80 per cent of deaths. The THIRD delay only about 20 per cent. So, the **MHTF should add a stronger community component, including an accountability mechanism which provides feedback**, i.e.
- MPDSR must provide a loop-**feedback to the quality of services**- so what happened, does not happen again – if feedback mechanism is not working, MPDSR is not useful.”

**Group discussion, UNFPA
Uganda national staff,
Kampala, May 2021**

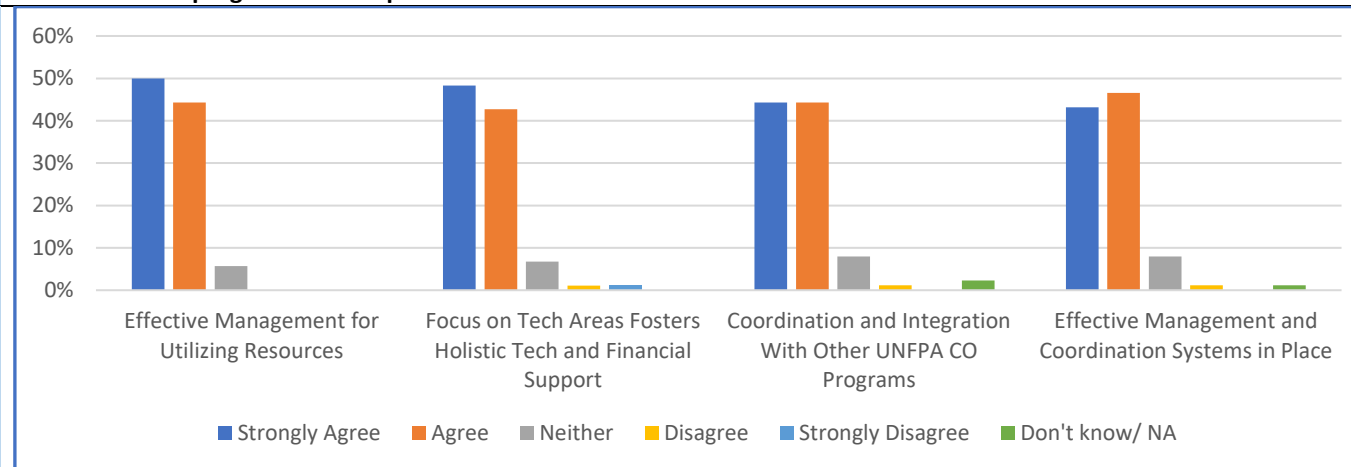
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| Zambia | |
| <ul style="list-style-type: none"> ● See Area of Investigation 6 for information on examples on integration across sexual, reproductive, maternal, newborn, child, and adolescent health agenda. | |
| <p>MHTF implementation challenges:</p> <ul style="list-style-type: none"> ● Delay in release of MHTF funds led to delays in implementing some of the supported activities such as finalization of the Operational Plan to End Obstetric Fistula. ● Due to the delayed release of the revised Global MPDSR Guidelines, the country did not revise the existing national guidelines as these need to be aligned to the global guidelines.” (p.2-3) ● Late remittance of MHTF resources was identified as an issue. “I know that it is not their fault for timely remittance of funds so that we can implement funding. The needs of the country are more than the funding received. We are only given USD 300K/year for all these components. Funds are always not enough. We are grateful that we have it as catalytic in all areas. I hope the programme can continue and expanded to other components (integration).” | <p>UNFPA Zambia. 2019 Annual Report. 2020.</p> |
| <p>Strategic decision-making under MHTF</p> <ul style="list-style-type: none"> ● Regarding strategic decisions: COs are encouraged to choose among the four technical areas where there is the greatest need. Funds are limited and meant to be catalytic; however, it is sometimes difficult to address an issue in a resource poor setting. In the case of fistula, the need is great, but it requires a lot of investment for training specialist doctors to repair fistula and many of the fistula clients are vulnerable, extremely poor and not linked to existing social security systems (i.e., social cash transfers). “More guidance is needed within UNPFA on how best to innovate and extend the MHTF scope of work around fistula, especially when it comes to linkages with social protection areas.” ● When it comes to midwifery, it is possible to reduce work in this area because the needs are huge and there is not the capacity to support every nurse-midwife who wants to go to school. “The priority should be to support the strategic areas at the national level and strengthen the linkages between the National Midwife Association and the MoH.” ● One of the areas that requires strengthening is the culture of data collection and use of data in policy and programme implementation. “What I have noticed is that there is the push to collecting the data at service delivery point, make use of it and make the decisions. Very little analysis and reflection. There is a need to strengthen routine data collection, analysis and reporting. Hopefully MPDSR can be used as a process for this; for every woman that dies, there are many others. We need to begin to use the data at the service delivery point level. Could help with iatrogenic fistula if this were recorded systematically.” ● MHTF is an extremely important stream of funding for maternal Health in Zambia, given high maternal mortality. One of the key indicators is significantly high MMR. “This fund is extremely relevant for Zambia, even though there has been a decrease. But we also have high neonatal mortality. Neonatal mortality has been increasing for past 5-6 years. With HR for Health, component for MWs is a big issue. There is high proportion of SBAs and high proportion of women who deliver in health facilities, quality of care is not good. Competencies and skills of MWs are not up to speed. The issue of having competent MWs and MW training is critical. There are significant challenges in EmONC – absence of appropriate equipment, staff not having appropriate skills, challenges with infection control, absence of drugs and supplies. Areas that require significant investment.” | <p>Interview, UNFPA Zambia national staff. August 2021.</p> <p>Interview. UNFPA Zambia staff, Lusaka. August 2021.</p> <p>Interview. UNFPA Zambia staff, Lusaka. August 2021.</p> |

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver

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| <ul style="list-style-type: none"> ● The MHTF mechanism does not allow for a lot of flexibility to do work outside of the four technical areas. “I suggest going forward, the fund is more flexible to allow countries to decide the areas of investment as long as they contribute to MH. For example, lots of work on social determinants on maternal health. Lot of work that could be done on that. When one looks critically at these four areas, many of the challenges are within the health facility. Important that we look at areas that are not within the health sector. That thinking might help to broaden our approach to reducing. Reason: combination of donors’ preferences and also an issue of capacity. We do not always have staff with expertise/broad mindset to look at social issues: If we are to root cause analysis for maternal death, there are so many factors we could identify. The usual default is to look at the issues of the MoH because we work with the MoH we have an agreement with them year end and year out, they are always our partner. Many of our officers do not have sufficient warm bodies to work across the sectors. We may never be able to change some of the outcomes if we do not take a holistic.” | <p>Interview. UNFPA Zambia national staff. August 2021.</p> |
| <ul style="list-style-type: none"> ● To advance the ICFP agenda, UNFPA cannot work alone. UNFPA partners with UNICEF on joint programmes on MNCAH and each takes an area of focus that complements the other. The joint programme (DfID) just ended, but the agreement is going on in separate areas in two provinces (Western and Central), although resources are not adequate. This makes partnership all the more important. “We maintained the agreement health system strengthening in RMNCAH; the programme itself was redesigned for UNFPA to focus on ADH and FP, with UNICEF focused on nutrition under the same agreement up to September this year with a no-cost extension.” | <p>Interview, UNFPA Zambia staff. August 2021.</p> |
| <ul style="list-style-type: none"> ● In general, UNFPA provides both financial and technical support, but “it has been dwindling, especially for technical support from outside the country when we do not have the competency locally.” The focus has not been as technical as in the past. Also, recently, the MoH has not played as active a role in the identification and evaluation of consultants. There used to be better coordination with UNFPA in this area. “In some cases, this appears to slip our fingers. Maybe we can make a better effort. When we just find a consultant is on board, we think we could have done better.” | <p>Interview, MoH Zambia national staff. August 2021.</p> |
| <p>UNFPA CO perspectives on integration across four technical areas of MHTF</p> <ul style="list-style-type: none"> ● “When you tackle maternal health, it is not just fistula, EmONC also comes in. When you look at your transformative results, a number of things come in. Maternal deaths MPDSR and training the provincial teams on MPDSR so that we reduce the mistakes being made and tackle the things that are preventing delays – transportation. Train the safe motherhood action groups SMAGS to ensure the community is able to demand SRH services, safe delivery and the babies that are safe. Preventing unnecessary abortions.” | <p>Interview, UNFPA Zambia national staff. August 2021.</p> |
| <ul style="list-style-type: none"> ● “For us, EmONC/MPDSR/MW/Fistula are integrated in Zambia. We cannot remove one – they all contribute to maternal well-being. <ul style="list-style-type: none"> ○ EmONC supports health care providers that are key to preventing maternal deaths. ○ Supporting midwifery curricula, when we see gaps, we come in to support so that the curriculum in line with ICM and adapted to the cultural situation in Zambia. We also support the midwives’ association, as they need an enabling environment and trainings. so that they have a voice and continuous training and education. We support their scientific conferences, research so that they can improve. | <p>Interview. UNFPA Zambia national staff. August 2021.</p> |

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| Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver | |
| <ul style="list-style-type: none"> ○ We support MPDSR; the midwives are the ones that come in contact with the women. They are the ones that feel bad when the woman dies in their care. We need midwives that are skilled in timely referrals and care. Midwives are encouraged as part of the MPDSR team. ○ When it comes to fistula, why did this woman end up with a fistula – usually because of prolonged and obstructed labor. The ANC should educate clients about the need for facility/hospital delivery, set aside emergency funds to book transport. They go early to facility maternity homes until they have skilled delivery. So we need to continue to educate them – even at the hospital. Dedicated people. Once this woman is prepared. Community should be able to refer a woman who is leaking urine for further treatment.” ● “For these 4 technical focus areas, we see them as interrelated. It is OK for silos to exist in the headquarters. We do not know much about the silos; we report to a number of people when we write ONE report, and we just copy them. We do not see much of the silos in that respect. We implement the activities, send one report and copy all.” | |
| <p>Technical support from regional office and headquarters</p> <ul style="list-style-type: none"> ● At the ESARO, there is only one member who works on maternal health. The MHTF work does not get regular reviews or systematic reviews on an annual or mid-year basis, likely due to capacity. “The team is not well coordinated at headquarters, MW advisor, fistula, MPDSR and EmONC – we do not get that coherence.” MHTF would benefit mid-year reviews with every country or within the region or focus countries coming together to discuss sharing, look at experiences. Some COs have innovations, and it would be helpful to share across implementation countries. ● “We need to see how we can transition out of the fund. There is not a clear exit strategy.” | Interview, UNFPA Zambia national staff. August 2021. |
| <p>Implementing partner perspectives</p> <ul style="list-style-type: none"> ● One suggestion for improvement would be a longer implementation period. “First and foremost, the implementation period is not long enough, and it is a challenge to be able to being able to adequately implement activities, obtain information from the ground and improve on those activities.” The situation has been compounded by the challenges of COVID-19; it would have been good to have the opportunity of an extension. ● A second suggestion is to ensure that partners fully understand the objectives and all the components of the project. “Better understanding at an early stage would have enabled us to redesign our implementation plan in a way that would have enabled more effective implementation. For example, the component on persons with disability was only added this year.” | Interview, NGO staff, Zambia. August 2021. |
| Online survey | |
| <p>Question 17: Looking forward, how can UNFPA strengthen its contribution to MNH and SRHR in your country?</p> <ul style="list-style-type: none"> ● Maintain coordination meetings and review meetings. At beginning of each year planning sessions should be encouraged. This improves understanding of tools used. Continue mobilization of resources and distribute accordingly. Procurement of equipment to be strengthened for facilities <p>Advocate and get more funds to continue the supports they have been providing especially in midwifery education</p> | Online Survey conducted between May and July 2021 |
| Question 19: Dimensions of effective management by UNFPA | |

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver



| | Strongly Agree | Agree | Neither | Disagree | Strongly Disagree | Do not Know/ NA |
|--|----------------|---------------|--------------|--------------|-------------------|-----------------|
| Effective Management for Utilizing Resources | 50.00% | 44.32% | 5.68% | 0.00% | 0.00% | 0.00% |
| Focus on Tech Areas Fosters Holistic Tech and Financial Support | 48.31% | 42.70% | 6.74% | 1.12% | 1.12% | 0.00% |
| Coordination and Integration with Other UNFPA CO Programs | 44.32% | 44.32% | 7.95% | 1.14% | 0.00% | 2.27% |
| Effective Management and Coordination Systems in Place | 43.18% | 46.59% | 7.95% | 1.14% | 0.00% | 1.14% |

Question 19: What are your thoughts regarding alternative approaches and ways for the MHTF to deliver high quality technical support within the limitations of its funding and programmatic arrangements?

- Organizing the MHTF around **the four technical areas helps to provide entry points** into the maternal health trajectory. It also presents a framework that UNFPA can use to advance specific themes in the dialogue
- It is possible to weave the maternal health story from family planning, midwifery, EmONC, fistula, and maternal and perinatal reviews and access to quality services using a logical thread of progression
- There is **room for better coordination and timely disbursement** of the fund. Need to increase the volume of the fund considering the quantum of the challenges
- **Review meetings need to be conducted as planned.**

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver

- Leveraging of resources to avoid duplication. UN working as one has assisted strategizing government priorities as there is One Plan and resources are allocated according to the thematic areas
- **We are still not effectively coordinated and therefore, there is lack of a comprehensive and holistic approach** within programs, SRH, youth and GBV.
- To ensure effective delivery and prevent working in silos within country, I suggest that the SRH and youth areas be unified and not working in split teams.
- Also, there is not expertise at CO in the area of data. All technicians should be expert in relevant data, indicators of the three transformative results
- MHTF funds should be limited to the provinces with lower MNH indicators and areas of focus should be defined by CO due limitations of budget.

Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization

Indicators:

- **Advisory Committee role is clearly identified through terms of reference and performance standard**
- **Meetings and other engagement enabled the Advisory Committee to meet its terms of reference**
- **Materials distributed in the form of briefing and information sharing were sufficient to ensure the Advisory Committee could provide strategic guidance and oversight**
- **Guidance of the Advisory Committee was considered and incorporated into the MHTF approach and rollout efforts**
- **Trends in resources mobilized and constraints identified**
- **Advisory Committee contributed to resource mobilisation strategy**
- **Examples of resource mobilisation efforts and results**
- **Examples of inter-relatedness of funding modalities within MHTF and between MHTF and other funding streams in UNFPA including core funds**

Observations

Sources of Evidence

Global

- **Governance: The MHTF will keep a light coordinating structure to strategically provide focused and catalytic technical and financial resources to selected countries.** The MHTF complements UNFPA core and non-core resources. Existing UNFPA accountability lines will be used in which CO teams operate under the leadership of the UNFPA Country Representative, who reports to the Regional Director, who in turn reports to the Deputy Executive Director, Programme and the Executive Director.
- **As a global thematic fund for MNH, the MHTF will continue to be coordinated by UNFPA headquarters** in collaboration with UNFPA regional offices. Oversight will be provided by an MHTF Advisory Committee, chaired by the Director of UNFPA Technical Division and co-chaired by the Chief of the Sexual and Reproductive Health Branch, who reports to the Director of the Technical Division.

The MHTF UNFPA, Business Plan Phase III (2018-2022), unknown publication date, New York, 2018

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| <ul style="list-style-type: none"> ● The committee will be made up of representatives from donors contributing to the MHTF (one representative per donor), a representative from UNFPA Non-Core Funds Management Unit and MHTF focal points from the five regional offices with MHTF-supported countries (West and Central Africa, East and Southern Africa, the Arab States, Latin America and the Caribbean, and Asia and the Pacific). ● The committee will also include representatives from the ministries of health of MHTF-supported countries (one country per region will be selected by the committee, and countries will rotate on an annual basis). Committee members may, in consultation with all members, invite other relevant parties to take part as required. The key tasks and responsibilities of the committee are described in Annex 1. It will meet once a year (mid-year) to discuss progress and results achieved, and to provide strategic directions and guidance. Meetings will take place in New York unless otherwise agreed. | |
| <ul style="list-style-type: none"> ● ...surprised that family planning in UNFPA is not grouped with SRHR in the UNFPA structure. Maternal health is part of SRHR but not family planning. Maternal health is underpinned by family planning, so we need more joined up approaches on this... ● Donors are not always willing to support family planning though and may prefer to support a narrow set of interventions. We need to shape the narrative to build commitment to the whole range of interventions. Issue is how to drive SRH and MNH integration in ways that carry more and more partners. | Interview, UNFPA global staff, May 2021 |
| <ul style="list-style-type: none"> ● Role of the advisory board is intended to be light-touch and to support communication and participation without creating a burden. | Interview, UNFPA global staff, May 2021 |
| <ul style="list-style-type: none"> ● Appreciate the advisory board idea and being consulted/included in some decision making. Donors need to understand what happens with their resources for internal accountability purposes, so this is helpful. ● It also helps build alignment which is very important – at global, regional and other levels. | Interview, Global Funding Partner, July 2021 |
| Regional | |
| <ul style="list-style-type: none"> ● No observations | |
| Benin | |
| <ul style="list-style-type: none"> ● Examples of the interdependence of funding modalities within the MHTF and between the MHTF and other UNFPA funding lines in Benin, including equity, are presented in section EQ7 on the catalytic effect and in EQ5 on integration | |
| Sudan | |
| A flexible vehicle | |
| <ul style="list-style-type: none"> ● Can see the value of the MHTF but there is a ceiling of financial limits ● MHTF contributes to all the three major UNFPA goals: GBV, maternal health and family planning ● The MHTF is flexible to respond to country needs but is linked to MNH. A focused intervention therefore and could probably have a wider remit. “Not clear the value of having a standalone MHTF as it could be more effective to have the fund be able to channel funds attached to each of the three transformative goals of UNFPA” ● MHTF could be the pathfinder to support the way the UNFPA works on/channels funds towards the three ‘endings’. Look at UNFPA investment to be more into the three transformative results | Interview, Leadership team, UNFPA CO, Khartoum, Sudan 23 June 2021 |

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| <p>Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization</p> <ul style="list-style-type: none"> ● MHTF would then be the pilot for the first of the three transformative results. Capitalise on the MHTF and mobilise resources for the three results learning from where and when the MHTF works. | |
| <p>Functionality of MHTF in the Sudan Context</p> <ul style="list-style-type: none"> ● Maternal mortality is exacerbated by the three delays: decision to seek care, finding transportation to a health care facility, ensuring the availability of resources and knowledge to refer if needed? CPR is very low, and sixty percent of the Sudanese population is comprised of young people. ● MHTF funding is a “drop in the ocean” compared to what is needed; there are four ways to get more value from the MHTF: <ol style="list-style-type: none"> 1. Fewer countries: The MHTF should invest in fewer countries but channel more resources to each one. Currently resources are channelled too thinly across countries. 2. Fewer priorities: The MHTF should focus on fewer technical issues and challenges in each partner country to avoid spreading resources too thinly across too many priorities. 3. More scope to use MHTF resources for human resources: MHTF resources should be available to source high quality technical staff who would then lead/galvanise fund raising for major activities rather than the current situation where MHTF is for activities but not technical assistance. ● Integration: There should be a greater focus on integrating all basic services into PHC. RH is just one of multiple components and it is more productive to work towards a strong system that can delivery all seven basic types of services offered by the PHC Platform (vaccination, RH, MNH, nutrition and child growth monitoring etc). | <p>Interview, UNFPA Leadership, UNFPA - Khartoum, Sudan, 9 June 2021</p> |
| <p>Technical and Systems Support also needs Coordination and Leadership</p> <ul style="list-style-type: none"> ● The MHTF is a useful vehicle and has made available crucial resources for maternal health ● The EmONC Network process and work is particularly valuable and high impact ● Jean-Pierre Monet, Dr Dalya Eltayeb, Dr Ahmed Sidahmed have really led the EEmONC process in Sudan and have made an enormous difference to impact, “a guiding experience” ● It was a huge exercise using a scientific approach with population and geography and roads all considered as well as other objective factors. It was an important step forward to building a systems strengthening process and very meaningful as a contribution to the delivery of services for maternal health. There are many dimensions to it, and they have found ways to enhance the use of the EmONC Network even further. It does and will continue to help the country to strategize other investments. ● But now, in addition to EmONC, UNFPA needs to do more to strengthen advocacy for multi-level coordination, for strategic investment and for targeted support working with others and building coherence. ● Other partners are sometimes the coordinators because UNFPA is not always there and not able to step up when needed to coordinate and lead or support the FMoH to lead. ● Need to optimise maternal health interventions to maximise the value of partnership. | <p>Interview, UNFPA CO leadership, Khartoum, Sudan 23 June 2021</p> |

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| <ul style="list-style-type: none"> Particular support was received from Jean Pierre in MHTF HQ and also from Sarah in the midwifery programme of MHTF. | <p>Interview, RH Coordinator, UNFPA CO, Khartoum, 17 June 2021</p> |
| <p>UNFPA grip on the MNH mandate and issues</p> <ul style="list-style-type: none"> In Sudan, UNFPA needs both technical and financial resources to support the country effectively, to provide guidance and then also mobilize others to support activities. Issues also involve GBV and a range of complexities. UNFPA needs to reposition its resources over the full mandate of the organization. Needs to regain control on coordination on issues of maternal health. UNFPA at different levels should re-gain coordination of the mandate. Lagging behind in that and more agencies are coming to fill perceived gaps. UNFPA not mobilising resources effectively. Major cuts from the UK on family planning for example – this will impact countries and ability of UNFPA to deliver its agenda. UNFPA needs to take a leading role on advocacy of this agenda. There are serious gaps in Sudan and it falls on UNFPA shoulders to mobilise to fill these and to support the government. Need to ensure WHO and other partners are very well oriented around the needs and can bring their resources to bear in a coordinated and constructive way to address agreed priorities. | <p>Interview, Leadership, UNFPA CO, Khartoum, Sudan 23 June 2021</p> |
| <p>Coordination, Partnership and Advocacy</p> <ul style="list-style-type: none"> These three elements – coordination, partnership and advocacy – need to be included as the MHTF is not just about how to use the resources at country level but actually what entry points the MHTF creates at the country level. However, there is a question about whether the coordination at global and regional level is also being done. Given the limited funding, the identification of strategic interventions is essential to maximising impact. Question then is HQ (and regional offices) also doing the coordination and partnership and advocacy at the higher level in ways that complement and support/reinforce the MHTF in countries. | <p>Interview, UNFPA CO, Khartoum, Sudan 23 June 2021</p> |
| <p>Broader context of sustainable change needed in Sudan Lessons from supporting fragile transitions point to the importance of building an inclusive and resilient social contract between citizens and the state and strengthening the legitimacy and capacity of core institutions. (Para 44).</p> <ul style="list-style-type: none"> The World Bank will capitalize on its comparative advantage of working through country systems to strengthen Government capacity and build trust in the institutions. Partnership with UN agencies will be critical to successful Bank engagement in early recovery activities especially in regions emerging from conflict building where UN has a strong comparative advantage (para 48). | <p>World Bank Sudan Country Note, 2020, Khartoum Sudan - Country Engagement Note for the Period FY21-FY22 (English). Washington, D.C.: World Bank Group. http://documents.worldbank.org/curated/en/879871602253859419/Sudan-Country-Engagement-Note-for-the-Period-FY21-FY22</p> |

Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization

National: Uganda

- MHTF supports “pre-determined” interventions – “if you want to introduce a new intervention, you have to drop one of the pre-determined interventions, but they are also important, so difficult for us to drop one of them.” The MHTF funds are very limited, so hard to drop one intervention. The funds are limited, **the expectations are high**, and the problem which we are trying to address is so huge and complex.”
- The lack of flexibility in planning of MHTF is key – perhaps there **is a need to focus more on catalytic effects to gain more**. The challenge is that we often need follow-up activities – there is no more additional activities, then you have to drop another activity. It was programmed for 5 years, from 2018-2022. Those activities are already there, so if we want to add another activity, it has to be added within the existing work plan/budget.
- MHTF has predetermined activities/indicators – so if there is a new activity/approach, it might not be supported. “This is a particular MHTF challenge – the work plan issue, we indicated this as an issue at the global MHTF fund a couple of weeks ago.”
- “We have the opportunity to have new donors/funding sources. We should use MHTF to fund catalytic activities – to have other donors take on and scale-up.”
 - “What we can do differently” – I think it is bringing the demand/community component into the MHTF, i.e., demand creation for fistula repair at community level, midwifery at community level.
 - Midwife should/will be at the centre of achieving our goals for maternal health. The support to midwifery in terms of regulation, association etc. – we are unique in that area, not many partners are supporting midwifery.
- We also have a demographic dividend (DD) approach – we make sure that the DHOs and partners understand our entry point is the adolescent girl – the teenage girl and the DD should be an entry point for maternal health and SRHR services. Also relate it to “keeping the girl in school” and “empowerment of the girl”. Putting the adolescent at the centre is a key strength of UNFPA.”

**Group discussion, UNFPA
Uganda national staff,
Kampala, May 2021**

Online survey

Question 18: Open Comments

- The multi-year funding approach adopted by the MHTF helps to bring certainty of funding to the discussion table but UNFPA failure to guarantee that funds will be available as planned frustrates that confidence.
- MHTF is a very good catalytic fund that supports critical areas of UNFPA mandate. One area that we need to work more on is the abortion care.

**Online survey conducted
between May and July 2021**

Area of Investigation 9: COVID-19

Evaluation Question 9: To what extent has the MHTF been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level due to the COVID-19 pandemic?

Sub-questions:

- a) To what extent have MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRH services amidst the pandemic to ensure access to a continuum of comprehensive life-saving maternal and sexual and reproductive health services as part of the COVID-19 response and recovery efforts?
- b) To what extent did the MHTF reallocation of funds and reprogramming help maintain the continuity of SRMNH services, in particular maternity services; ensure the protection of healthcare workers (particularly obstetricians, midwives and anaesthesiologists); and strengthen the SRMNH coordination mechanisms in response to COVID-19 at national and sub-national levels?

| Evaluation criteria | <i>Relevance, efficiency, coordination, sustainability</i> |
|---------------------|---|
| Rationale | In 2020, the COVID-19 pandemic spread to every country in the world leading to a range of complex and far-reaching health, socio-economic and other impacts. COVID-19 affected the health system and equitable access to MNH and SRHR services in detrimental ways. UNFPA working alongside other partners adopted a flexible approach to ensure continuation of access to RMNCAH services. The reprogramming and reallocation of funds, combined with mobilisation of additional resources for the emergency response, was aimed at mitigating the negative effects of COVID-19 on the ability of the health system to deliver quality MNH and SRHR services and to ensure continuous access to those services. MHTF partner countries pivoted their health system capacity to prevent, identify, treat and manage COVID-19 cases. UNFPA, including the MHTF, like other United Nations agencies and global partners, took steps to support countries to respond quickly and effectively to COVID-19 while ensuring the continuity in the provision of essential services. |

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts

Indicators:

- Number of MHTF funded assessments conducted on continuity of essential and lifesaving RMNCAH services amidst COVID-19 pandemic
- Documented and reported adjustments in MHTF programmes in terms of scope, timing, and targeted outcomes in light of the pandemic at global and country levels
- Examples of joint work by thematic teams within MHTF and across UNFPA to prioritise and address the COVID-19 related needs of partner countries
- Examples of how MHTF processes, activities and goals continued to be delivered even during the COVID-19 response where that was possible
- Examples of policies and programme adjustments related to practical changes and reorganisation of processes or systems
- Participation by UNFPA and the MHTF in studies and reviews to assess the impact of COVID-19 on women and adolescents and identify critical needs for support to them as the COVID-19 pandemic unfolded
- Incorporation of the response to COVID-19 impacts into annual MHTF plans and budgets.

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|--------------|---------------------|
| Observations | Sources of evidence |
|--------------|---------------------|

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts

Global

- No observations

Regional

- **Takeda**, a global pharma company based in Japan, **provided grants to respond to COVID-19**, including one to UNFPA for PPE distribution in the form of funding support to three countries.
- COVID-19 funding to UNFPA MHTF for COVID-19 response efforts in Sub Saharan Africa. Supplying critical PPE to PHC workers. It has gone well in their view. They like that UNFPA has tried to introduce innovation into the delivery of PPE like drone technology – e.g. in Benin.
- Chose MHTF because UNFPA said this was the best way to channel the funds. UNFPA also selected the three countries.
- They have received quarterly updates and reports and financial narrative from UNFPA. Country reps invited to the progress review calls.
- Waiting for the final results. Then will synthesise and publish the data. (See below)

Interview, Development partner (foundation), September 2021

- UNFPA **mobilized health ministries, public and private partners, media and communities** to ensure the continuity of quality MNH services. A monitoring system tracking the provision of services and the number of women and newborns benefiting from the partnership with Takeda found that after three months of implementation, the number of targeted EmONC health facilities providing services 24/7 increased from 11 per cent to 23 per cent in Guinea and from 40 per cent to 50 per cent in Togo. Preliminary results indicate that obstetric activity was maintained and even increased compared to the same period in 2019.

UNFPA, MHTF Annual Report 2020, 2021, p.28

- The MHTF **collaborated with UNFPA Asia and the Pacific Regional Office and the Burnet Institute** to develop comprehensive technical guidance to ensure the continuity of essential maternity services and protection of the health workforce.

UNFPA, MHTF Annual Report 2020, 2021, p.27

Bangladesh

- **Telemedicine** has been introduced for ANC during COVID-19 times. Thus, of the eight ANC visits, four can be made through telemedicine. About 2,000 telemedicine sessions were done by midwives and 827 PNC sessions. There is an increase in number of facility normal-vaginal-delivery in those centres which undertook telemedicine – Bangladesh Midwifery Society took the initiative to distribute masks to all the midwives deployed in the field.

International Midwifery Specialist, UNFPA, Dhaka, Bangladesh, June 2021

- Emergency needs **identified by the government** by cutting down activities in ongoing programmes and rechanneling funds/resources to meet immediate needs. For example, the mentorship programme in different peripheral facilities were put on hold and mentors were redirected to instead focus on COVID-19 readiness of respective facilities.

International Midwifery Specialist, UNFPA, Dhaka, Bangladesh, June 2021

- The UNFPA response to the COVID-19 crisis evolved on the basis of observed needs. Several ongoing initiatives were adjusted to respond to these needs. Thus, midwife mentors in government centres switched their roles to make those centres COVID-19 ready. UNFPA arranged ‘low dose high frequency’ training to enable the mentors to play their new role. A team of ‘roving midwives’ was put in place to help conduct deliveries in peripheral government facilities (Upazila health complexes). Between October 2020 and March 2021, about 30,000 deliveries were conducted by these midwives. In two of the biggest medical

International Midwifery Specialist, UNFPA, Dhaka, Bangladesh, June 2021

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teaching institutes of the country (DMCH and SSMCH), existing midwifery services continued during COVID-19 times in dedicated COVID-19 wards. The midwives also stepped in to support teaching students placed in delivery wards.

- **Strengthening the National Midwifery Programme (SNMP)** effectively collaborated with the government and other agencies and contributed to the development of the national preparedness plan for COVID-19. The project participated in virtual coordination and consultative meetings with the MOH&FW and other partners and contributed to the development and update of COVID-19-related technical guidelines and briefs, and the establishment of monitoring mechanisms. SNMP also contributed to developing national training modules on IPC prepared for service providers and support staff (drivers, cleaners). Immediately after the declaration of the COVID-19 pandemic in the country, SNMP, along with other support agencies, helped the government design and conduct facility readiness assessments of government-declared COVID-19 dedicated hospitals across the country.
- This **helped to understand the existing health system preparedness** to respond to the pandemic and identify service gaps to address. SNMP supported assessments at 14 COVID-19-dedicated hospitals that were already part of its programme. Before starting the assessment, assessors were oriented on the assessment tool through a structured training program facilitated by health facility assessment experts from DGHS and development partners. Considering the potential risk of infection during data collection, different protocols on infection-prevention practices, including proper use of PPE, were emphasized in the training. The project supported the DGHS to roll out countrywide training on IPC and COVID-19 clinical case management with a focus on the project-assigned 16 districts.
- Thus, 933 government staff (527 doctors and 406 nurses) were oriented on IPC and 958 staff (549 doctors and 409 nurses) were oriented on COVID-19 case management. Mentorship and Capacity Building SNMP existing clinical mentors extended their advocacy and technical support to government staff to respond to COVID-19 as outlined in the new working strategy. Before starting their support to hospitals, clinical mentors were oriented through inhouse virtual training on COVID-19-related maternity topics using global and national guidelines and videos, especially technical briefs published by UNFPA. All mentors were **oriented on infection-prevention practices and national MNH guidelines**, jointly organized by DGHS and development partners, with the goal of cascading the training in their facilities. Mentors were provided with PPE such as reusable gowns, masks, gloves, and hand sanitizer for use during the facility visits. Clinical mentors used a comprehensive checklist developed jointly with UNFPA to identify and address hospital gaps related to COVID-19 readiness.
- Major sections of the checklist included **triage and isolation facilities, handwashing and infection-prevention practices, provider knowledge on COVID-19 topics, and service provision status**. This checklist also guided a clinical mentor to support hospital staff methodically in responding to COVID-19 and routinely monitor the progress of the hospitals. Progress was shared during district and Upazila-level monthly meetings. Clinical mentors not only supervised the entire process but provided regular face-to-face mentoring to increase the competency and confidence of midwives and other nursing staff required to provide safe, quality services in the context of the COVID-19 pandemic. Clinical mentors also incorporated COVID-19 prevention and counselling into ANC.

UNFPA, Health System Response to COVID-19, 2020, p.2

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| <p>Several decisions were taken to make the hospitals safe for obstetric and newborn services. Hospitals have undertaken activities such as:</p> <ul style="list-style-type: none"> ● Continuing outdoor ANC services during office hours ● Strengthening the quality of remote ANC ● Utilizing dedicated midwives for SRHR services ● Involving field staff for demand creation for EmONC service utilization ● Capacity development of staff and readiness to receive and manage routine and emergency obstetric cases. These activities resulted in increased uptake of EmONC services from July 2020 onwards. | <p>UNFPA, Health System Response to COVID-19, 2020, p.3</p> |
| <p>Recommendations:</p> <ol style="list-style-type: none"> 1. The national level should promote functionalizing an effective “triage system” at all facilities. 2. Ensuring implementation of national COVID-19 maternity guidelines at the facility level under close supervision of district managers. 3. Monitoring of hospital IPC by establishing an IPC committee or identifying a focal person. 4. Engaging district- and Upazila-level quality improvement committees for monitoring, supportive supervision, and continued capacity building of service providers in responding to the COVID-19 pandemic. 5. Community mobilisation and sexual behaviour change communication activities through the existing health staff for improving hospital utilization for SRHR services. 6. Effective utilisation of midwives along with structured mentorship for ensuring safe maternity care. 7. Inclusion of COVID-19-related SRHR indicators into the national routine MIS (DHIS2). 8. Proper management of the supply chain through functionalizing automated logistics (LMIS) system for the logistics necessary to respond to the COVID-19 crisis. | <p>UNFPA, Health System Response to COVID-19, 2020, p.9</p> |
| <ul style="list-style-type: none"> ● The SNMP COVID-19 response strategy is designed to support UNFPA response to the COVID-19 pandemic, which directly aligns with the national preparedness and response plan to combat COVID-19. In line with the WHO global COVID-19 preparedness plan, Bangladesh developed its response plan to contain the spread of infection by putting in place a mechanism for early detection, quarantine, and treatment of infected persons, along with strengthened surveillance capacity nationwide. The second goal of the national plan was to ensure the safety of health workers and clients so that routine health services can continue. The national response plan was scheduled to be implemented through a multisectoral coordination and partnership mechanism under 10 technical pillars that included infection prevention and control, COVID-19 case management, ensuring essential health services delivery, planning coordination and response strategy, logistics and procurement, risk communication and community engagement, and research. | <p>UNFPA, Health System Response to COVID-19, 2020 year, p.1</p> |
| <ul style="list-style-type: none"> ● UNFPA response to the crisis was crucial: When PPEs were hard to access and good quality PPEs were not available, UNFPA provided midwives with 4000 reusable PPEs, online training on donning and doffing and training on infection prevention. This allowed midwives to continue services unabated even during the peak of the pandemic. UNFPA helped to launch telemedicine | <p>Midwifery Officer, Nursing and Midwifery, Dhaka, Bangladesh, June 2021</p> |

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| <p>at this time which saved women from coming to centres for ante natal care. UNFPA also put in place systems for midwives and nurses in centres to share training and information on COVID-19.</p> | |
| <ul style="list-style-type: none"> ● Roving midwives intervention was introduced during the crisis. OGSB, WHO, UNICEF were mobilized who along with UNFPA lobbied DGHS to prioritize this intervention. Telemedicine was introduced for ANC. UNFPA also arrange short term appointment of technical staff to manage the extra workload during the pandemic. UNFPA worked with WHO, UNICEF, BRAC, USAID and other NGOs to set up community support teams in Dhaka North and South City Corporation areas for community awareness and actions – later this was replicated in rural areas as well. | <p>Health System Specialist, UNFPA, Dhaka, Bangladesh, June 2021</p> |
| <ul style="list-style-type: none"> ● Thirteen districts were provided with transportation support cost to collect sample for COVID-19 suspected patients for COVID-19 response for surveillance and laboratory support (Pillar 1). OGSB facilitated strengthening the health system to provide accessible and affordable quality of care and service to reduce maternal mortality focused on PPH/ eclampsia and standard labour room practice at District Hospital and Medical College Hospital. | <p>UNFPA, 2020 Mid-year Report MHTF Bangladesh, 2021, p.1</p> |
| <ul style="list-style-type: none"> ● UNFPA was quick to respond to the COVID-19 crisis. Through DGHS, UNFPA funded temporary staff for call centres and government facilities, provided PPE of the best quality and within a very short time, ensured that labour rooms were operating in all facilities with midwives. UNFPA organized anaesthetist and obstetricians for some centres, and most importantly, held hands of field-based teams reassuring and encouraging them to do their best during these trying times. Tele-medicine service was introduced through midwives which has taken off well and will probably be in place post COVID-19. | <p>Immediate Past President, Obstetrical and Gynaecological Society of Bangladesh, Dhaka, Bangladesh, June 2021</p> |
| <ul style="list-style-type: none"> ● At national level, UNFPA works as part of the UN coordinated response to the COVID-19 pandemic under overall leadership of RC (and COVID-19 outbreak coordinator) with WHO and other UN agencies, including H6. The response engages local governments, in particular the MoH, and other national and international partners to continue strengthening health systems. UNFPA should be part of UN country team discussions and joint impact assessment to ensure that sexual and reproductive health and protection impacts of COVID-19 at the country level are addressed. | <p>UNFPA, COVID-19 Internal Guidance Note, 2020, p.3</p> |
| <p>Benin</p> | |
| <ul style="list-style-type: none"> ● Non-financial support or technical assistance provided by this project to government, NGO, and civil society (names of recipients, description of support/assistance type, intensity, frequency, etc.). The UNFPA COs in Benin, Guinea and Togo organized virtual sessions with the MoH; particularly, the Family Health department, the regional health departments and a few actors from the private sector, such as the Private Health Sector Platform in Benin. These sessions contributed to: <ul style="list-style-type: none"> ● Facilitating the coordination of partners involved and preparing the implementation of the project in the COVID-19 context. ● Developing COVID-19 protocols and communication campaigns on COVID-19. ● Providing technical assistance for the planning and the delivery of several workshops (training on infection prevention and control, training on EmONC skills, training on maternal and perinatal deaths surveillance and response, and development of key messages on SRH, COVID-19 and continuation of services). ● Developing technical documents for the continuation of services and the monitoring of the implementation progress: home visits, outreach strategy, referral strategy, last mile distribution and performance monitoring. | <p>UNFPA and Takeda, Global CSR Progress Report, 2020</p> |

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| <ul style="list-style-type: none"> ● Appuyer les innovations en Santé maternelle : Appui à l'écosystème d'innovation pour le prototypage des PPE et autres besoins clés de la réponse COVID 19, déploiement des solutions et communication sur les stratégies innovantes ● En effet, une liste de différents équipements de protection fabriqués localement pour la protection des sages-femmes est identifiée. Les prochaines étapes prévoient que cette liste soit mise à disposition après une dernière étape d'analyse et de validation des besoins qui est en cours. ● Pour ce qui est du système de communication, les ressources sont mises à la disposition d'un partenaire de mise en œuvre au titre du troisième trimestre et un outil digital du nom de REMA pour le renforcement des capacités des sages-femmes et à leur formation continue est appuyée, fonctionnelle et en cours d'utilisation | <p>UNFPA Benin, MHTF report 2020</p> |
| <ul style="list-style-type: none"> ● Point positif : Mise en place du système de lavage des mains : Diminution des maladies liées à l'eau grâce aux mesures barrières ; baisse de diarrhée « un changement qui ne dit pas son nom ? Amélioration de l'hygiène parmi la population ● Impact négatif était la psychose – quand 1 malade vient avec un asthme, population troublée, stigmatisation ; envoi d'un test | <p>Entretien, Directeur de clinique, Mai 2021, Benin</p> |
| <ul style="list-style-type: none"> ● Lors du COVID-19, soutien du FNUAP avec du matériel de protection ; promotion de l'usage unique : champs/blouses deviennent plus chères. Les couts étaient difficilement supportables. Révision des systèmes de stérilisation. | <p>Entretien, Centre de Santé, Mai 2021, Benin</p> |
| <ul style="list-style-type: none"> ● UNFPA : seul partenaire rencontré durant COVID-19. Ils ont visité, ont aidé le service de réanimation et la stérilisation (autoclaves remplacées – risque d'explosion) ● Impact COVID-19 : Premier centre détecté parmi personnel ; tous les services ont alors fermé et le personnel mis sous surveillance. Conséquence : Fréquentation diminuée. Un mois après, les activités ont repris. Conséquences négatives sur la réputation. Mais les choses sont rentrées dans l'ordre. Taux de natalité accru (600-700 naissances en Avril/Mai) – jamais atteint les autres mois. | <p>Entretien Directeur d'hôpital, Mai 2021, Benin</p> |
| <ul style="list-style-type: none"> ● COVID 19 : Dotation en matière de prévention On nous avait promis blouses des sages-femmes dans le cadre de l'Année de la sage-femme, mais on n'a jamais reçu – ça fait partie des mesures barrières | <p>Entretien, sage-femme, Juin 2021, Benin</p> |
| <ul style="list-style-type: none"> ● UNFPA a doté la maternité de TOUROU de matériel de protection, ce qui a permis la continuité des services. Matériel pour le lavage des mains, les bavettes, les gels hydro alcooliques, gants etc. Sans eux, il aurait été difficile de fournir les services dans la période | <p>Entretien Personnel de santé du district, Mai 2021, Benin</p> |
| <ul style="list-style-type: none"> ● Beaucoup d'impacts : Fréquentation a beaucoup diminué ; certains personnels ont laissé le travail ; on a reçu les intrants pour prévention (masques/gel hydro) : UNFPA et autres. Difficile les premiers mois puis on a commencé activités ● Pour les cas d'aggravation, on fait la référence ● Hygiène : On a redoublé de vigilance : Cas de rhinite ont diminué, lavage des mains a entraîné la diminution des cas de diarrhées et d'infections ; j'ai apprécié de porter le masque, quand bien-même on a l'air d'étouffer. On a aussi constaté une diminution du risque d'allergie dû à pollution (en saison pluvieuse, nombreuses rhinites/bronchites) | <p>Entretien, sage-femme, Juin 2021, Benin</p> |

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| <ul style="list-style-type: none"> ● Le COVID-19 a ralenti la mise en œuvre des différents programmes parce que c'est vrai que le Bénin comparé à d'autres pays a été moins impacté en termes de fermeture des activités parce que ça a été juste fait un mois et après plus ou moins la vie a repris. | Entretien, Partenaire Technique et financier, organisation multilatérale Août 2021, Benin |
| <ul style="list-style-type: none"> ● Donc en termes d'impact, je dirai qu'il n'a pas eu un grand impact comparativement à d'autres pays mais quand même ça a retardé un peu la mise en œuvre des activités. | Entretien, Partenaire Technique et financier, organisation multilatérale Août 2021, Benin |
| <ul style="list-style-type: none"> ● Mais sur le terrain en termes de continuité des soins, on a senti quand même que la COVID-19 a eu un impact sur la vaccination de santé de la mère et de l'enfant. On a senti quand même comparativement aux mêmes périodes d'activités des années précédentes, il y a quand même eu un recul des indicateurs | Entretien, Partenaire Technique et financier, organisation multilatérale Août 2021, Benin |
| Sudan | |
| COVID-19 and health related changes in the Sudan Context | |
| <ul style="list-style-type: none"> ● By March 2020, the first case of COVID-19 was reported in Sudan, followed by a declaration of the state of health emergency. This was in force until August 2020. ● The health system of Sudan is weak, and it was not ready to respond to the impact of COVID-19 with relatively high case fatality rate compared to the global data. The capacity to respond was affected by the limited financial and human resources as well as shortages in essential and lifesaving medical supplies. ● Annual flooding affects people; during 2020, heavy rains and flash floods affected 557,000 individuals in 17 out of 18 states. An assessment conducted by UNFPA indicated 57 health facilities were partially destroyed by floods and heavy rains. ● Around 1.3 million positive malaria cases were diagnosed during 2020 until September, pregnant women and U5 children are identified as at high at risk. Viral haemorrhagic fevers cases reached 2,863 affecting mainly northern and eastern states, as well as Darfur states. and recently the influx of the Ethiopian refugees from the Tigray region in the eastern zone of Sudan, have further exacerbating the humanitarian needs, including access and availability of health care services. ● While the plan for Sudan CO MHTF workplan in 2020 was endorsed early in the year, due to the COVID-19 pandemic there was a major need to revise the plan and consequently the amendment was done toward the end of semester one in 2020. The majority of the activities of the original work plan were not feasible due to the need of social distancing, as well as the movement restrictions due to the state of emergency. ● Both the CO and HQ agreed to amend the work plan to reflect and address the competing and emerging priorities, including supporting the functionality of the lifesaving and essential SRHR services during COVID-19. | UNFPA, 2020 template for MHTF reporting, 2020, UNFPA, Khartoum, Sudan |
| UNFPA focus on maternal health during COVID-19 | |
| <ul style="list-style-type: none"> ● As part of the operationalization of its Global Response Appeal, and in addition to the support provided through the MHTF, UNFPA proposes to ensure access to quality MNH during the COVID-19 pandemic in nine countries with a high burden of maternal mortality and morbidity that are among the most affected by COVID-19 in Sub-Saharan Africa...including Sudan... | UNFPA, Review of COVID-19 Response in nine countries, Results Indicators Framework, UNFPA, 30 April 2020 |

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| <ul style="list-style-type: none"> • This proposal will complement UNFPA support to countries and regions in these nine countries affected by humanitarian crisis and fragility. It has been developed by the UNFPA COs and regional offices in support of the ministries of health's responses to COVID-19 and in collaboration with UN partners and NGOs. • The proposed response duration is nine months (from May 2020 to January 2021) to ensure the continuity of MNH services during the COVID-19 pandemic and the recovery and strengthening of the health system after the crisis. | |
| <p>Justification for maternal health focus during COVID-19 on Sudan (and eight other countries)</p> <ul style="list-style-type: none"> • These are countries with fragile and poorly resourced health systems. • A limited number of hospital beds per population, poor infrastructure, skilled health care providers and medical supplies, rendering them unable to quickly scale up an epidemic response. • A large proportion of their populations live in crowded cities with poor conditions and the need to earn money daily to survive. • Despite having young populations...some countries in the region have a high prevalence of disease that require immunosuppression (such as HIV and AIDS); hypertension; and diabetes which may result in sharp increases in the number of deaths due to COVID-19. • These conditions are also risk factors for pregnant women, implying increased maternal mortality due to underlying risk factors. | <p>UNFPA, Review of COVID-19 Response in nine countries, Results Indicators Framework, UNFPA, 30 April 2020</p> |
| <p>Activities undertaken early in the COVID-19 response</p> <ul style="list-style-type: none"> • Contribution to COVID-19 response for 11 prioritized EmONC health facilities. This includes ensuring functionality of critical EmONC facilities and ensuring the availability IPC supplies, and the "procurement process is initiated; items are expected to be received by August 2020". | <p>UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>Rapid provision of materiel</p> <ul style="list-style-type: none"> • UNFPA is very supportive of the hospital both directly and through the FMOH. • Provided consumables especially during COVID-19 when most of the health facilities were closed and the needs were beyond what the State hospital could meet. • UNFPA provided PPE, medications, including magnesium sulphate and misoprostol covering all needs at the hospital. • Furthermore, they provided some midwifery delivery kits including caesarean section kits and gynaecological theatre kits. | <p>Interview, Referral Hospital Medical Director, Sudan, 5 June 2021</p> |
| <p>MHTF Annual Work Plan (AWP) affected by COVID-19</p> <p>Some activities were fully cancelled:</p> <ul style="list-style-type: none"> • Examples: Intention to conduct an assessment of Damazin and Al-Fashir midwifery schools to identify gaps (linked to the application to ICM for accreditation of midwifery curriculum) was cancelled for 2020. • Review and finalization of the professional midwifery education programme, including the undergraduate and postgraduate midwifery curricula and education materials development and associated activities were all cancelled. <p>Other activities were curtailed:</p> | <p>UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020</p> |

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| <ul style="list-style-type: none"> Support to the MoH at national and states levels to monitor the network of EmONC facilities (including monitoring of the deployment of skilled staff, MNH data using the agreed upon indicators and referral links) which is the third phase of the EmONC process were not fully achieved due to movement limitations. | |
| <p>Disruptions of COVID-19 on MHTF programmes</p> <ul style="list-style-type: none"> Direct MHTF supported programmes were mainly re-programmed because of movement restriction and the fact that the majority of activities were centrally based. Many services were stopped as a result of the lack of PPE etc. so prioritising this was urgent and relevant. MDSR was affected and community verification was affected – could not effectively perform community-based verification while lockdown restrictions were in place. Neither could they do EmONC monitoring. Had to go for procurement of PPE to support delivery of basic services for PPE. MHTF funds were reprogrammed to ensure service continuity and for the procurement of PPE. FMoH people were not working 100% and the capacity to do the EmONC monitoring, and the associated prioritisation and response plan was affected and delayed. | <p>Interview, UNFPA CO, Khartoum, Sudan 23 June 2021</p> |
| <p>Impact of COVID-19 on service utilization</p> <ul style="list-style-type: none"> FMoH conducted an assessment of the impact of COVID-19 on the availability of services: ANC 12 per cent reduction; Access to EmONC and facility-based deliveries at EmONC-based deliveries reduced by 9 per cent; and access to skilled birth personnel was 18 per cent. Reduction in access to family planning as well. | <p>FMoH report reviewed and summarised during Interview with the UNFPA CO, Khartoum, Sudan, 23 June 2021</p> |
| <p>UNFPA Lessons Learned</p> <ul style="list-style-type: none"> The immediate response of UNFPA to COVID-19, “as illustrated by the contingency planning, facilitated the application of the required modification to the programmes supported by the agency”. COVID-19 had significant implications on the programme continuity. Most of the planned activities were revised to accommodate the COVID-19 prevention. Youth engagement in SRH/COVID-19 awareness campaigns ensured that SRH/COVID-19 response plans were targeted to sensitive and responsive youth-specific needs and expectations. | <p>UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>Coordination with partners</p> <ul style="list-style-type: none"> Pooled support among UN agencies/the H6 partners in country During COVID-19, UNFPA led the SGBV sector. | <p>Interview, UN Partner, 9 June 2021, Khartoum</p> |
| <p>Uganda</p> | |
| <p>UNFPA support for guidelines for service continuity</p> <ul style="list-style-type: none"> UNFPA estimated that 1,269,817 pregnant women in the country face increased challenges in accessing lifesaving SRH services. The long period of school closure and lockdown measures contributed to increased teenage pregnancy rates by 1.55 per cent (in UNFPA supported districts). The Uganda Police reported a 10% increase in cases of GBV in 68 districts and a 17% | <p>UNFPA Uganda, Final Annual Report for MHTF, 2020</p> |

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| <p>increase in SGBV cases nationally, attributing it to a combination of increased tension, stress and confinement conditions in the household.</p> <ul style="list-style-type: none"> ● “With the introduction of the COVID-19 SOPs, UNFPA worked with MoH to produce guidelines for continuity of health services as well as online content and training materials (Quality of Care) that could be accessed by health workers remotely. Using the online applications, interventions on capacity building and coordination were not greatly affected. <p>COVID-19 Pandemic caused suspension and postponement of most of the activities and change in means of engagement in compliance with the COVID-19 Prevention and Control guidelines especially for activities that require gathering of people like fistula repair camps.</p> <ul style="list-style-type: none"> ● Using Online platforms for training and coordination was a challenge for participants living away from the urban centres due to the fact that internet access is limited in these areas.” (p.20) | |
| <ul style="list-style-type: none"> ● UNFPA support the MoH with PPE materials, they supported continuation of essential services, the implementation of the national guidelines to support the continuation of the essential services. They also did continued advocacy for the continuation of essential services at the district level. | <p>Interview, MoH official, Kampala, May 2021</p> |
| <ul style="list-style-type: none"> ● UNFPA has made a significant contribution to MoH efforts to improve policies and strategies for MNH, including the national PPH Action Framework, the RMNCAH Investment Case/Sharpened Plan (GFF), National MPDSR Costed Implementation Plan (see details further below), the RMNCH COVID-19 National Guidelines (Provision of RMNCAH Services during the COVID-19 Pandemic) and the National Guidelines for Continuation for Essential Services. ● In addition to the policies, UNFPA provided significant support alongside other partners to ensure the continuation of RMNCAH services during COVID-19: “Partners came into restore essential services during COVID-19, a lot of the support came from UNFPA.” ● In the early days, during lockdown, there were gross restrictions in access, because of restrictions of movement, so there was low performance, very low uptake of family planning. Of all the MNCH indicators, family planning had the biggest drop, the family planning uptake was very low, especially in April 2020. It recovered from June and above, when MoH came in to establish the weekly meetings for “continuation of essential services” and many partners came in to support the response and to ensure continuation of essential (including SRHR) services. Many partners were reprogramming of resources. “I remember we ran out (uterotonics – drugs to control PPH, and also magnesium sulphate – UNFPA buffered up of that. Second leading cause of maternal deaths is hypertensive disorders in pregnancy. The cost of uterotonic increased during that time; normally it costs 3.000 but went up to 20000, Ugandan Shillings, per private partners.” ● Partners came into restore essential services during COVID-19; a lot of the support came from UNFPA | <p>Interview, MoH official, Kampala, May 2021</p> |
| <p>Service provider perspectives</p> <ul style="list-style-type: none"> ● During COVID-19, UNFPA procured several items for EMONC including PPE to help continue maternal health services and protect health workers. | <p>Interview, MoH Service provider, Kampala, May 2021</p> |

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts

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| <ul style="list-style-type: none"> ● Gulu is one of the four districts that received UNFPA COVID-19 support in 2020 for PPE/IPC for midwives. ● COVID lockdown had major impact on access to MNH services – people only came for emergency services, while routine services such as ANC and immunizations dropped significantly during the first month of the lockdown. There were also travel/transportation restrictions. Led to more maternal deaths during that period. ● UNFPA supported the district with PPE for midwives to ensure that they could continue MNC services during this period. ● Boda-bodas and DHO vehicles (including ambulances) received “stickers” from MoH allowing them to circulate even though all public and private transportation was prohibited for 2 months (mid-March – end May) | <p>Interview, MoH service providers, Gulu District, May 2021</p> |
| <ul style="list-style-type: none"> ● “Last year, when COVID-19 pandemic broke out, UNFPA engaged ... I am happy that UNFPA is on the ground, we work together all the time. With the lockdown that was imposed, it was very difficult for mothers to access health facilities.” ● UNFPA provided critical support to ensure the protection of health care workers, the continuation of SRHR service provision during the lockdown, as well as referrals access to those services by communities who could not reach the health facilities by their own means. Examples: <ul style="list-style-type: none"> ● UNFPA support to the two additional ambulances was “very critical support” and helped saving mothers’ lives during the COVID-19lockdown because they helped “pick the women at designated points who could not come to the health facilities themselves because of transport restrictions”. ● UNFPA also funded “fuel cards” to facilitate transportation of health workers to communities (to identify/map pregnant women and conduct outreach services) and referrals/ambulance services to help transport patients to health facilities – since all public and private transportation was banned during a two-month period. ● Also, the “fuel cards” were used to support the UNFPA ambulance to pick up blood supplies from the blood bank in Gulu city centre (150 km from Lamwo) as blood supply became very scarce during the COVID lockdown. ● UNFPA provided PPE for MNH health care workers including facemasks, surgical masks, gumboots, gloves, heavy duty gloves, sanitisers etc. (UNICEF also provided similar support). This helped protect clinical providers and as a result, only very few were infected with COVID-19 (there were more infected support/admin/cleaning staff). ● Before COVID-19 broke out, biweekly health partner coordination meetings were held in the district where the clinical teams would meet separately every two weeks, e.g., partners in nutrition, WASH, FP/MCH etc. would meet separately. When COVID-19 broke out, this got disrupted. “But we have now resumed, especially with partners in MCH services – we now meet every month – we have had two meetings so far. UNFPA has always been in attendance, we invite them, and they always come to attend, and they guide us a lot. They are a big partner with many programmes and districts, but still they spare time to come and participate.” | <p>Interview, MoH service providers, Lawmo District, May 2021</p> |
| <p>UNFPA support for service continuity</p> <ul style="list-style-type: none"> ● The MoH work plan was revised to incorporate the supported COVID-19 response activity on training in IPC and follow up. A total of 159 service providers, especially midwives in four identified districts of Gulu, Otuke, Pader and Omoro were trained and mentored in IPC measures. UNFPA mobilized resources to procure PPEs worth USD 464,165 for health facilities in 46 | <p>UNFPA Uganda, Final Annual Report for MHTF, 2020</p> |

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| <p>districts and supported 1,579 health workers with transport to health facilities in 28 districts. USD 134,829 was used to purchase fuel for ambulances to provide transport to access SRH services in 32 districts.</p> <ul style="list-style-type: none"> • Districts were supported to procure fuel cards to facilitate referrals during the COVID-19 epidemic. 5000 mothers supported with referral. A Total of 4,791 women were supported from 55 UNFPA districts, of these, 2,668 mothers were supported using MHTF Funds with transport to deliver in Gulu and Pader districts during the period of lockdown and 51 mothers were supported to receive emergency obstetric care in the same period. • UNFPA supported the conduct of IPC measures including training and mentoring of service providers particularly midwives, in COVID-19 infection prevention and control strategies and linkages to SRH and GBV, availability, printing, dissemination of IEC materials and risk communication. Prevention of COVID-19 transmission was enhanced through training in IPC in 6 districts, provision of IEC materials on COVID-19 (17,700 pieces of IEC materials on COVID-19 both in English and local languages were printed and distributed in 55 districts including the four districts of Gulu Omoro, Pader and Otuke under MHTF). | |
| <ul style="list-style-type: none"> • Entries for progress against workplan indicators/activities were noted as “0 per cent completion.” | <p>UNFPA Uganda, GOU/UNFPA Country Program Support to MoH 2020 Annual Work Plan, 2020</p> |
| <p>UNFPA perspective</p> <ul style="list-style-type: none"> • “I believe we have played a great role in ensuring “continuation of essential service” – in supporting mechanisms that were in place, TWG, there has been a lot of support for policy development. Two, at the service delivery level, we made a very deliberate move to support the different DHOs with fuel and money/cash to ensure safe delivery services.” | <p>Interview, UNFPA Uganda national staff, May 2021</p> |
| <p>Zambia</p> | |
| <p>Development of guidance for essential public health services during COVID-19:</p> <ul style="list-style-type: none"> • UNFPA, WHO, UNICEF, PEPFAR, USAID, and Stop TB supported the MoH, Directorate of Public Health in the development of these guidelines. • The guidelines called for a strategic shifts or principles for Provincial and District Health Officers as Health Facility in-Charges: <ul style="list-style-type: none"> ○ “Identification of context-relevant essential services ○ Optimization of service delivery settings and platforms ○ Establishment of effective patient flow (screening, triage, and targeted referral) at all levels ○ Rapid re-distribution of health workforce capacity, including by re-assignment and task sharing ○ Identification of mechanisms to maintain adequate essential medications, equipment ^[1]_[SEP] and supplies ○ Health worker well-being and joy in the workplace ○ Infection prevention and control of COVID-19 in the areas of service provision and beyond” (p.7). • The following priorities were highlighted in order to prevent communicable disease, avert maternal and child morbidity and mortality, prevent acute exacerbation of chronic conditions (such as HIV and TB) and manage emergency conditions: | <p>MoH, Zambia. General Guidance: Provision of Essential Public Health Services During the COVID-19 Pandemic. May 2020.</p> |

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| <ul style="list-style-type: none"> ○ Promotion of good practices in hygiene, nutrition and health-seeking behaviours ○ Prevention for communicable diseases, including vaccination ○ Reproductive and child health, including family planning, care during pregnancy, childbirth, postnatal and infant care. ○ Other categories: diagnosis and provision of medications and supplies for on-going treatment of chronic diseases, including mental health; continuity of critical inpatient services; auxiliary services, such as basic diagnostic imaging, laboratory services and blood bank services. ● The guidance included chapters on infection prevention and control of COVID-19 in service provision, and monitoring and supervision needs, as well as those relevant for the difference areas of public health, i.e., SRH, child health, nutrition, adolescent health, non-communicable diseases during COVID-19, essential mental health services amidst COVID-19, malaria, HIV, TB, neglected topical diseases and community health. ● The guidance also includes specific guidance for SRHR. An example of selected guidance follows: <ul style="list-style-type: none"> ○ “The population’s sexual and reproductive health needs continue even under the time of a pandemic. Pregnancies planned or unplanned and hence obstetric emergencies will continue. There is likelihood of increase in pregnancies due to challenges in accessing contraception. This may result from; women and girls not wanting to risk COVID-19 infection through visiting the health facility; lack of health care providers at health facilities due work overload and absenteeism occasioned by infection among health care providers; stock-outs of contraception and abortion commodities and other commodities in general. The COVID-19 pandemic can increase sexual violence and subsequently unintended pregnancies. Sexual violence is a form of GBV, and primarily occur between intimate partners. Thus, women need access to comprehensive sexual and reproductive health care and information. This includes family planning, ANC, care during childbirth, PNC, contraception, safe abortion care services, prevention, testing and treatment of HIV as well as STIs, detection and treatment of GBV. Women’s choices and rights to sexual and reproductive health care should be respected irrespective of COVID-19 status.” (p.12) | |
| <p>Development of guidance for essential RMNCAH services during COVID-19</p> <ul style="list-style-type: none"> ● The MoH issued guidelines for the provision of RMNCAH&N services during the COVID-19 pandemic, intended for use by healthcare care providers providing services to women of reproductive age including adolescent, pregnant and lactating mothers, the newborn as well as children under the age of five. It is not meant to replace existing guidance or provider judgment, but rather to strengthen clinical management of these patients, and ensure continuity of essential service package for women and children. The technical guidance was prepared with support from ZAGO. With contributions from the Zambia Paediatric Association, Midwifery Association of Zambia, Medical Women Association of Zambia and cooperating partners for their input ● Examples of selected guidance includes the following: <ul style="list-style-type: none"> ○ “Routine Maternal and Newborn Care services: In order to reduce maternal and newborn mobility and mortality, there is an ongoing routine maternal and new-born care services that the systems adhere to. For the response of COVID-19, | <p>MoH, Zambia. Guidelines for the Provision of RMNCAH&N Services for COVID-19 Containment in Zambia. November 2020.</p> |

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| <p>the routine services will be continued with clear guidance for reduction of the spread of the virus. Pregnant women will continue to visit the health facilities except in the case of a lock down. During these visits, there will be adherence to standard procedures by the client and the services providers.</p> <ul style="list-style-type: none"> ○ Functional triage: At the level of the health facility where other members of the population are seeking care, a triage service should be in place. Pregnant women and new-borns should be prioritized. ○ Quality isolation services: For the COVID-19 health response, isolation services will be provided for affected cases. Pregnant women and new-borns should receive isolation services that provides quality maternal care services for maximum outcome. Each patient should have a separate room with attached bathroom and doors closed at all times. The facility should ensure appropriate and consistent use of PPE by all people entering the patient’s room. ○ Precautionary Observation Centre (POC): A designated space with at least two MNH service providers should be available at every POC for pregnant woman and women with newborn. Pregnant women, mothers and new-borns should immediately be taken to the designated room, suitable for the majority of their stay at POCs. All precautionary IPC measures should be taken, and care should be provided according to their specific needs. ○ Treatment Centre: Every treatment centre should have a designated space and at least four (4) MNH service providers like nurse, midwife etc. Pregnant women, mothers and newborn, should be provided with necessary support and IPC care during their stay. Care should also be taken during the provision of drugs as to reduce risk of miscarriage or other adverse outcome. ○ IPC: Infection prevention control measures should be included in all service provision package for pregnant women and new-borns. PPE should cover the clothing and skin and should completely protect mucous membranes when caring for pregnant women and new-born with suspected or confirmed COVID-19. Individuals unable or unwilling to adhere to infection control and PPE use procedures should not provide care for patients with COVID-19.” (pp. 11-13) ● “Home visits may be preferable, provided the woman and everyone in her household is well. Maternity staff attending homes should be mindful of exposure to COVID-19 in a home visit and should adhere to strict infection control procedures when entering and leaving homes. It has been shown that the coronavirus can survive on surfaces for up to 17 days. Maternity staff should be provided with appropriate personal protection equipment as per public health guidelines when providing care for women with suspected infection or when entering homes where other members of the household have symptoms.” (p. 16) | |
| <p>Collaboration to ensure essential services during COVID-19</p> <ul style="list-style-type: none"> ● UNFPA, UNICEF and others supported government to have a strategic approach on how things should be done to ensure that essential services are continued, while taking into account the safety measures for clients, communities and providers. These guidelines did help the GOZ maintain a fairly high level of health services. The government has documented that COVID-19 had an impact, i.e., a 10-15% reduction in clients accessing services. Indicators will see a dip. | <p>Interview, multilateral organization national staff. August 2021.</p> |

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| <ul style="list-style-type: none"> ● The monitoring of the effects of COVID-19 is on-going between Government and partners. A huge meeting planning meeting is envisioned for the coming year. The MoH has reviewed the past three years, and there has been a big variation between 2019 and 2020. Since then, we the trend has been more positive, and the system has adjusted. “We know that COVID-19 is around, and now we know how to provide services.” Periodically, WHO conducts a “desktop survey” on what has been happening with health services. It is done by the UN jointly, but WHO is producing this.” [Note: The WHO informant did not respond to any requests for an interview, despite many tries.] | |
| <ul style="list-style-type: none"> ● There is a study underway to determine impact of COVID-19 on service delivery and on maternal deaths themselves (with WHO). Some of the maternal deaths were among women infected by COVID-19. It is not clear how to classify these deaths. “Initially, WHO did not include COVID-19 mothers as maternal deaths. But people argued, if they have malaria, it is a maternal death; why not COVID-19? Whichever women dies while pregnancy, we need to review to determine whether a COVID-19 or a MH death. Need more clarification by WHO. From the data, we just observed that a number of services decreased during pandemic lockdowns and access by communities was affected.” | <p>Interview, MoH Zambia national staff. August 2021.</p> |
| <p>Togo</p> | |
| <ul style="list-style-type: none"> ● Une enquête coordonnée par le bureau WCARO et conduite par le bureau pays n’a pas démontré une répercussion négative sur l’utilisation des services en temps de COVID-19 ; cependant les violences basées sur le genre a pays un tribut à l’épidémie. Les dépenses pour la prévention constituent désormais une part importante des dépenses sur le programme qu’il désormais prendre en compte dans les plans. La prévention dans COVID a beaucoup impacté les mesures de prévention et de contrôle de l’infection peu appliquer dans nos systèmes de santé. | <p>UNFPA, MHTF Request Proposal 2019-2022, 2019</p> |
| <ul style="list-style-type: none"> ● La pandémie a eu un impact sur le progrès de la mise en œuvre des PTA, mais ceci n’est due qu’à une hésitation dans « comment gérer les programmes avec la COVID-19 » au début de la crise où tous, on espérait une issue rapide. Le mode travail en virtuel, même pour certaines formations a été une réussite et constitue un outil qu’on pourra toujours utiliser dans les contextes où la distanciation ne sera pas de mise. - Un suivi rapproché de la mise en œuvre des recommandations faites lors de monitoring SONU est indispensable. Ceci fera l’objet des missions de suivi dans le PTA 2021. | <p>UNFPA, MHTF Request Proposal 2019-2022, 2019</p> |
| <ul style="list-style-type: none"> ● COVID-19 33. Qu’a fait UNFPA au Togo pour répondre et s’adapter au COVID-19, par exemple : a. Ajustement des politiques et programmes Non b. Réaffectation / reprogrammation des ressources Oui c. Mobilisation de fonds supplémentaires au niveau national ou régional spécifiquement pour relever les défis de la SMN et de la SDMR face au COVID-19 Oui Takéda d. Participation de l’UNFPA pour évaluer l’impact du COVID sur les femmes et les adolescents et identifier les besoins critiques de soutien Oui, à travers une initiative de WCARO | <p>UNFPA staff, UNFPA, June 2021, Togo</p> |
| <ul style="list-style-type: none"> ● Présentement nous sommes dans les tentes comme vous les voyez la maternité est en rénovation. C’est en cette période de COVID-19 que vraiment les partenaires (UNFPA) sont venus voir les conditions dans lesquels nous travaillons et qui n’étaient pas du tout bonne et ils ont décidé de nous aider et c’est la réhabilitation qu’ils sont en train de faire. Mais comme le partenaire (UNFPA) veut toujours la continuité des soins, ils ont jugé bon de nous mettre dans les appâtâmes, les tentes pour continuer la prestation donc c’est ce que nous faisons et sans vous mentir dans les tentes les conditions de travail, ne sont pas | <p>Midwife, Government, June 2021, Togo</p> |

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| <p>vraiment bonnes. Les conditions de travail ne sont pas bonnes : respecter la distanciation, respecter les mesures hygiènes ... (Réhabilitation de la maternité pour améliorer les conditions de travail et d'accueil).</p> | |
| <ul style="list-style-type: none"> Le partenaire qui nous a aidé pour la réhabilitation, c'est UNFPA avec le projet Takeda. Le projet Takeda était déjà là avant la COVID-19, mais vu les conditions dans lesquelles nous étions en train de travailler, ils ont jugé bon de nous aider et c'est leur objectif, objectif de leur projet c'est eux qui sont en train de réhabiliter notre local. | <p>Midwife, Government, June 2021, Togo</p> |
| <ul style="list-style-type: none"> Nous avons reçu les équipements de protection individuelle, les bavettes, tout ce qui faut pour la protection individuelle. Les visières pour les yeux tout ça. On nous dotait aussi en kits d'hygiène, savon liquide, eau de javel pour pouvoir faire le lavage des mains régulièrement. Il y a des dispositifs de lave-mains. Ils ont agi par rapport à comment éviter l'infection pour ce qui concerne le personnel. Mais comme je l'ai déjà dit par rapport aux femmes enceintes, nos conditions de travail ne permettent pas de respecter la distanciation. C'est au regard de tout cela que l'UNFPA est en train de faire la rénovation de la maternité. Des sensibilisations ont été faites sur les radios en négociant des plages horaires. Deux rapports sur l'impact de la COVID-19 ont été produits (dotation en équipements de protection individuelle, kit d'hygiènes, évaluation de l'impact de la COVID-19 sur le personnel). | <p>District Health Officer, Government, June 2021, Togo</p> |
| <ul style="list-style-type: none"> Le projet Takeda avait élaboré un document sur les normes en période de COVID-19. Nous en avons reçu. L'Etat aussi a fait un document qu'on nous a donné pour pouvoir prendre en charge des femmes qui seront contaminées au cours de COVID-19. Donc nous avons eu des documents que nous utilisons. | <p>District Health Officer, Government, June 2021, Togo</p> |
| <ul style="list-style-type: none"> Les soutiens en période de COVID-19, les formations SONU, le recrutement de sage-femme complémentaires, les kits de sécurité, les équipements, les intrants, la PF, toutes les formations dont j'avais parlé, les formations sur la réanimation du nouveau-né, les les notifications de décès maternels, tout ça, la réhabilitation de la maternité, les formations sanitaires qui ont bénéficié d'incinérateur, tout est sur les fonds UNFPA. | <p>District Health Officer, Government, June 2021, Togo</p> |
| <ul style="list-style-type: none"> Comme nous le savons, on ne peut dire que COVID-19 n'a pas agi. COVID-19 a agi sur les fréquentations parce que quand ça a commencé en même temps, les gens ont déserté les centres. Avec les sensibilisations, ça a repris. A la polyclinique de Tsévié, le problème que nous avons eu c'était le problème de respect de la distanciation. Nous n'arrivons pas à les respecter par rapport à nos conditions de travail. Au début on avait commencé par limiter le nombre de femmes que nous allons recevoir dans la journée. Mais depuis que le projet Takeda est arrivé il nous a aidés avec les kits d'hygiène et tout. Avec la nouvelle construction de la maternité, les conditions de travail dans le contexte COVID-19 seront améliorées pour bien respecter les mesures barrières qu'il faut (Faible utilisation des services ; difficultés à respecter la distanciation). | <p>District Health Officer, Government, June 2021, Togo</p> |
| <ul style="list-style-type: none"> Dans la lutte pour l'infection à COVID-19, les mesures barrières étaient un problème pour nous. Tout d'abord pour la prévention de cette infection par rapport au personnel même d'abord. Comment se protéger pour faire face cette pandémie. C'était un problème pour le personnel parce que le matériel de protection individuel n'était pas aussi trop disponible. C'était insuffisant. Par rapport à ça, l'UNFPA est intervenu en nous dotant de ces matériels de façon périodique. | <p>District Health Officer, Government, June 2021, Togo</p> |
| <ul style="list-style-type: none"> As part of the operationalization of its Global Response Appeal, and in addition to the support provided through the MHTF, UNFPA proposes to ensure access to quality MNH during the COVID-19 pandemic in nine countries with a high burden of | <p>UNFPA, Ensuring access to quality maternal and newborn healthcare</p> |

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maternal mortality and morbidity that are among the most affected by COVID-19 in Sub-Saharan Africa: Benin, Chad, Congo Brazzaville, Côte d’Ivoire, Guinea-Conakry, Madagascar, Senegal, Sudan, and Togo. This proposal will complement UNFPA’s support to countries and regions in these nine countries affected by humanitarian crisis and fragility. It has been developed by the UNFPA COs and regional offices in support of the ministries of health’s responses to COVID-19 and in collaboration with UN partners and NGOs. The proposed response duration is nine months (from May 2020 to January 2021) to ensure the continuity of MNH services during the COVID-19 pandemic and the recovery and strengthening of the health system after the crisis.

during the COVID-19 Pandemic, 2020

- The justification for focusing on Africa and these countries in particular is multifold. These are countries with fragile and poorly resourced health systems, with a limited number of hospital beds per population, poor infrastructure, skilled health care providers and medical supplies, rendering them unable to quickly scale up an epidemic response. In addition, as a large proportion of their populations live in crowded cities with poor conditions and the need to earn money daily to survive, there are major concerns of an acceleration of COVID-19 cases in sub-Saharan Africa. The pandemic will most likely negatively impact the progress made in increased numbers of institutional deliveries in these countries, with devastating consequences for timely access to quality delivery services including emergency care. In addition, the nine proposed countries have a robust maternal health program which enables a rapid response to COVID-19 at scale. They all have a rational network of maternity units, aiming to be better staffed and equipped to provide obstetric care and manage obstetric and perinatal emergencies. With UNFPA support, these nine countries have monitored obstetric data, which facilitates the interventions management and reporting.

UNFPA, Ensuring access to quality maternal and newborn healthcare during the COVID-19 Pandemic, 2020

Online survey

| Response to COVID-19 | Strongly Agree | Agree | Neither | Disagree | Strongly disagree | DK/NA |
|---|----------------|--------|---------|----------|-------------------|--------|
| Flexible and adaptive approach to ensure continuity of essential services | 39.90% | 47.47% | 5.56% | 0.00% | 0.00% | 7.07% |
| Strengthened Coordination and Reallocated Funding to Maintain Continuum of Services | 37.56% | 39.09% | 9.64% | 0.51% | 0.00% | 13.20% |

Selected responses to question about COVID-19

- Support FMOH on the COVID19 mitigation on sustaining the essential SRH functions
- UNFPA reprogrammed some of its funds to procure PPE for midwives to ensure safety but also continued MNH services.
- UNFPA established a maternity isolation and fully equipped with basic equipment to respond for pregnant women and postnatal women with COVID-19

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- Some MHTF funds were programmed during the COVID-19 pandemic to provide PPEs to supplement government's efforts at fighting the pandemic; and also to procure dignity kits for nursing mothers at selected delivery wards.
- IN response to the COVID-19 pandemic, the CO sought permission from HQ to use some of the MHTF resources to procure Infection Prevention Supplies including PPE. This ensured continuity of MNH services at the respective health facilities.
- Advocacy and awareness creation through mainstream and social media, integration of COVID-19 response with SRHR and gender programmes.
- As an IP we are getting guidelines of COVID-19 and follow the rules which is follow the UNFPA Bangladesh. as well as we also raising awareness among the beneficiaries
- During COVID-19, supported the RMNCAH Helpline services; development and dissemination of risk communication materials on SRH and COVID-19; implementation of remote ANC and PNC teleconsultation service.
- UNFPA was quite active and served as a co-lead in supporting the development of the RMNCAH training package in maintaining routine quality Reproductive health services during the COVID -19 outbreak in Liberia.
- UNFPA repurposed funds from its program to support the National COVID-19 response. Specifically, funds from the UNFPA Supplies Partnership, and MHTF were repurposed to ensure health workers have the protection they need to ensure continuity of essential services.

Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units

Indicators:

- National and subnational data DHIS2/HIMS indicate continuation of SRMNH services, in particular in maternity units
- Reported (quantitative and qualitative) effectiveness of UNFPA support to procurement, distribution and use of PPE by health care providers (in particular obstetricians, midwives and anaesthetists) to protect them against COVID-19 infections
- Examples of UNFPA support to SRMNH coordination mechanisms at national and sub-national level which has helped to prevent overlap/duplication and enhance complementarity and synergies with other SRMNAH programmes and actors.

| Observations | Sources of evidence |
|--|--|
| Global | |
| <ul style="list-style-type: none"> • No observations | |
| Regional | |
| <ul style="list-style-type: none"> • No observations | |
| Benin | |
| <ul style="list-style-type: none"> • Sur le terrain en termes de continuité des soins, on a senti quand même que la COVID a eu un impact sur la vaccination de santé de la mère et de l'enfant. On a senti quand même comparativement aux mêmes périodes d'activités des années précédentes, il y a quand même eu un recul des indicateurs | Entretien, Partenaire Technique et financier, organisation multilatérale août 2021, Benin |

| Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units | |
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| National: Sudan | |
| <p>Concerns about maintaining progress on MNH</p> <ul style="list-style-type: none"> • The pandemic will most likely negatively impact the progress made in increased numbers of institutional deliveries in these countries, with devastating consequences for timely access to quality delivery services including emergency care. In addition, the nine proposed countries have a robust maternal health programme which enables a rapid response to COVID-19 at scale. • They all have a national network of maternity units, aiming to be better staffed and equipped to provide obstetric care and manage obstetric and perinatal emergencies. • With UNFPA support, these nine countries have monitored obstetric data, which facilitates the interventions management and reporting. They are not only able, but also need to be at the forefront of efforts in making childbirth safe for all women and newborns during the COVID-19 pandemic. • These health facilities cover a majority of the population within one or two hours of travel time and their functioning is closely monitored, providing a response at scale and reactive to the needs of women and newborns. | <p>UNFPA, Review of COVID-19 Response in nine countries, Results Indicators Framework, UNFPA, 30 April 2020</p> |
| <p>Measures to ensure service continuity</p> <ul style="list-style-type: none"> • Temporary deployment of 20 additional skilled midwives in Nyala states to serve in five localities for period of three months to support the timely response to essential obstetric care • Contribution to COVID-19 response for 11 prioritized EmONC health facilities. This includes ensuring functionality of critical EmONC facilities and ensuring IPC supplies availability. | <p>UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan</p> |
| <p>Continuity of services</p> <ul style="list-style-type: none"> • During COVID-19 with UNFPA support, CAFA deployed several mobile clinics providing ANC and family planning services as well as distributing PPE to health providers. | <p>Interview, National NGO, Khartoum, 3 June 2021</p> |
| <p>Impact of COVID-19 on SRH service continuity:</p> <ul style="list-style-type: none"> • Interruption of service provision at health facilities: health care facilities including EmONC faced limited capacities in the first period of the pandemic, and limited number of facilities were operating. • Interruption of health care provided at community level: services mainly delivered by community midwives were impacted due to limitation on movement as well as low access to PPE/infection prevention materials and knowledge. • Referral services were consumed by COVID-19 cases creating significant gaps in ability to attend to non-COVID-19 cases. | <p>UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020</p> |
| <p>UNFPA support to risk communication</p> <ul style="list-style-type: none"> • Provision of technical assistance to FMoH and technical partners for the development of materials aimed at the general population as well as pregnant women, breastfeeding women, and health care providers linked to SRHR services • Support to youth-peer network to lead a nationwide COVID-19 risk communication campaign. Reached app 60,736 women and girls. | <p>UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020</p> |
| <p>UNFPA support to Case Management:</p> | <p>UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020</p> |

| Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units | |
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| <p>The MCH Directorate at FMOH jointly with UNFPA, WHO, and UNICEF led the development of the Technical Guidance for Provision of MCH services during COVID-19 Outbreak within Health Facilities and Communities, which included the essential package of services mandatory to continue, required triage, patient flow, and guidance for health care worker protection. The guidance led to a number of specific adjustments supported by UNFPA to ensure continuity:</p> <ul style="list-style-type: none"> ● A reassessment of the recommended number of health care workers at each facility depending on COVID-19 caseload ● Dissemination of case management protocols nationwide (printing and distribution) ● Mapping of isolation centres ● Identification of the SRHR gaps in each facility and improved provision of care to pregnant women and to women who have recently given birth, at risk of COVID-19 ensuring available lifesaving drugs and supplies, skilled health personnel and isolation room/location in EmONC facilities. | |
| <p>SRH Service delivery support by UNFPA during COVID-19</p> <ul style="list-style-type: none"> ● Referral of obstetric complications through supporting ambulances ● Distribution of IPC ● Distribution of inter-agency RH kits ● Continuity in the supply of medical commodities required for the clinical management of rape | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| <p>Current and expected needs</p> <ul style="list-style-type: none"> ● Active referral services in areas with limited access or interrupted services ● Supporting community midwives with midwifery kits, clean delivery kits, linkages with referral services ● Deployment of midwives to health facilities with human resource gaps ● Supply with inter-agency RH kits as well as family planning commodities ● Regular mapping of CMR services, updating the situation with pre-positioning of CMR kits. | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| <p>Infection Prevention & Control:</p> <ul style="list-style-type: none"> ● FMOH and UNFPA jointly worked on updating the training packages for infection prevention, which were specifically adapted to the RH context. ● Core team of trainers were trained at federal level, who conducted trainings at the 18 states of Sudan mid-April 2020, series of trainings were conducted to each strata of care providers, obstetric specialist & paediatricians (254), PHC care providers (452) and community midwives (1055) ● Adaptation of the training package to context of COVID-19 by using e-learning methods (videos) ● Moreover, UNFPA provided the critical EmONC facilities with infection prevention materials, “total of 12 facilities received supplies, and supplies covering ten facilities are in the pipeline”. | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| <p>UNFPA identified opportunities within the COVID-19 response:</p> <ul style="list-style-type: none"> ● Investing more in improving capacity specifically of EmONC facilities, including targeting them for the rehabilitation of referral services, as well as supporting community networking and referral ● Digitalization of care approach: strengthening coordination through regular mapping of services and supplies stock analysis | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |

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| <ul style="list-style-type: none"> ● Sustaining the provision of essential and lifesaving services through strengthening the capacity of health care providers ● Strengthening referral services including through limiting periods of stockout of life-saving drugs and supplies. | |
| In Blue Nile State <ul style="list-style-type: none"> ● UNFPA supported training and guidance to midwives to perform safe deliveries for COVID-19 patients, providing PPE to health providers and facilitating access to health services – especially EmONC – by contributing to transportation costs. UNFPA supported COVID-19 isolation units with kits, commodities, and supplies. | Interview, State MoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| <ul style="list-style-type: none"> ● Although the resources are limited, and there were needs for more consumables including masks and gloves, the patient load was lower than usual. | Interview, PHC Service Provider, Blue Nile, Sudan, 7 June 2021 |
| <ul style="list-style-type: none"> ● Through the SMoH, UNFPA organized advocacy training for midwives to conduct safe deliveries to COVID-19 patients. They provided some consumables as well. | Interview, Nurse-Midwife, Ad Damazin, Blue Nile State, 7 June 2021 |
| UNFPA support to maternal health outcomes during COVID-19 <ul style="list-style-type: none"> ● The main challenge of maintaining service delivery was the limited number of health providers ● From the triage unit, suspected or confirmed patients were referred to the isolation section at the hospital where they received services by trained health providers ● Midwives were trained to provide safe delivery for COVID-19 patients ● PPE, consumables and commodities were supplied by UNFPA ● Triage, midwifery training, PPE and other commodities were supported by UNFPA. | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile State, 7 June 2021 |
| UNFPA support to triage and patient management <ul style="list-style-type: none"> ● Health workers, including doctors, nurses and midwives, were trained to provide services for COVID-19 patients. ● A triage station was placed at the entrance of the Emergency Room and covered by a medical doctor and nurse to identify suspected COVID-19 patients, using simple measures like pulse oximeter, thermometer and taking some key information from patients. ● Suspected and confirmed COVID-19 patients were sent to an isolation centre where they received services from trained health workers (doctor and midwives). ● The challenge was to provide emergency caesarean section to women where no specialized operation room or staff were available to do it. The hospital used special staff to attend theatre and then closed the theatre until it was re-sterilized. ● Despite precautions, at this one hospital, two consultants died from COVID-19 and two other doctors were infected while providing the service to COVID-19 patients. | Interview, Referral Hospital Medical Director, Omdurman, Sudan, 5 June 2021 |
| UNFPA support according to the FMoH <ul style="list-style-type: none"> ● UNFPA supported midwives to perform safe delivery for COVID-19 patients (training, guidance, manual of instructions for triage and protection) ● The advocacy of midwifery to perform safe delivery to COVID-19 patients ● Provision to midwives of PPE and safe delivery kits | FMoH, Khartoum, Sudan, 1 June 2021 |

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| <ul style="list-style-type: none"> Support was also received for a few ambulances (covering operational costs) to ensure women could continue to access emergency assistance in pregnancy and childbirth. | |
| <p>Multiple emergencies; prioritised response</p> <ul style="list-style-type: none"> In the first wave, Sudan experienced wide-spread and very damaging flooding as well as COVID-19. Limited supplies were available, and these were pooled and directed towards the prioritised EmONC facilities in the network. Active coverage with PPE etc also focused on the EmONC network. Staff were redistributed to ensure the EmONC facilities were all functional. | Webinar presentation, FMOH, Khartoum, 17 June 2021 |
| <ul style="list-style-type: none"> During COVID-19, UNFPA was one of the main contributors and was a third-party in supporting monitoring the interventions and responding to the pandemic. | UNFPA Group Meeting, 5 June 2021, Khartoum |
| <p>Partnerships for COVID-19 response</p> <ul style="list-style-type: none"> The two organisations were part of the national emergency committee, hence the support was for pooling During COVID-19, “working closely with UNFPA who leading the GBV sector and promoting a hotline for GBV including associated policies and guidelines” Aware that UNFPA supported a number of ambulances for the emergency transfer of women in both Khartoum and Aljazeera state to improve access to services despite COVID-19 Also, aware that UNFPA provided PPE for health workers at several health facilities. | Interview, UN Partner, Khartoum, 3 June 2021 |
| <p>UNFPA coordination during COVID-19 response</p> <ul style="list-style-type: none"> UNFPA was actively engaged in the national and state level emergency preparedness and response coordination platform, including the health cluster. SRHR was a standing agenda at the government platform. The different technical working groups (on IPC, case management etc) linked to COVID-19. COVID-19 policy and resources coordination forum with OCHA relevant pillars’ lead and coordination forum. Primary health care departments and relevant counterparts to ensure reflecting the provision of essential SRHR services. | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| Uganda | |
| <p>Reprogramming 2020 MHTF resources</p> <ul style="list-style-type: none"> “Through the reprogramming of the MHTF the CO was able to support the procurement and distribution of the much-needed PPE for midwives to continue offering essential services during COVID-19 pandemic. In addition, through this reprogramming, a total of 16,347 pregnant women were able to receive services (ANC, delivery and EmONC) due to the successful provision of transport to health workers to access health facilities and pregnant women to seek medical care during the total lockdown at the onset of COVID-19 pandemic in Uganda. A total of 159 service providers, especially midwives in four districts of Gulu, Otuke, Pader and Omoro were trained and mentored in COVID-19 infection prevention and control strategies while administering the SRH and GBV services. In addition, IEC materials were generated to promote risk communication in these districts.” (p.4) | UNFPA Uganda, Final Annual Report for MHTF, 2020 |

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| <ul style="list-style-type: none"> ● “Infection Prevention and Control was strengthened in the context of COVID-19 with the training of 159 service providers (especially midwives), in four districts of Gulu, Otuke, Pader and Omoro. These healthcare providers were also trained and mentored in the provision of SRH and GBV services.” (p.6) ● “Infection Prevention for COVID-19 has significantly reduced cases of Sepsis in maternal care across the country.” (p.19) | |
| <ul style="list-style-type: none"> ● Funds earmarked to support the MoH to develop, produce and disseminate a documentary on the Midwifery programme in Uganda to make the International Year of the Midwife was reallocated to support MHTF salaries. ● Funds initially earmarked to support attendance at the 1) International Society of Obstetric Fistula Surgeons conference and Obstetric Fistula Global TWG meeting in Maputo; 2) International Confederation of Midwives conference in Bali; and Global MHTF and EmONC meetings were reallocated towards the COVID-19 response. ● Funds were reallocated to the COVID-19 response from EmONC activities, i.e., to support the MoH to mentor service providers in provision of quality EmONC services, including the roll out of the Quality-of-Care standards in one target district as per the road map for quality of maternal care in Uganda. | UNFPA Uganda, MHTF 2020 Mid-year Report, 2020 |
| Zambia | |
| <p>UNFPA CO reallocation of MHTG and other resources:</p> <ul style="list-style-type: none"> ● At national level, UNFPA reallocated funding to support the needs that arose; for example, at national level, this helped to support O2 requirements at one of the big hospitals as well as the procurement of PPE and infection prevention materials. The CO reallocated from other fund codes in addition to MHTF. The CO also supported the urgent need to reorient providers to infection prevention and control for COVID-19 mitigation measures. With regard to maternal health, PPEs were in short supply (goggles, face shields, coveralls) as was disinfectant. There was the need to educate support staff/cleaning staff, reorient patients and attitudes. ● “In more rural areas, there has been fear to come to facilities, coupled with existing in delays in seeking care, lack of transport. Talking to one of the nursing officers in Western province – we need more community engagement/awareness and messages with regard to COVID-19. It would be good to do some form of survey re COVID-19 to learn what is keeping the women from seeking care. What are the issues for health care providers? What are the fears? They are the ones more on the ground, supervising and seeing what on the ground.” | Interview, UNFPA Zambia staff. August 2021. |
| Bangladesh | |
| <ul style="list-style-type: none"> ● Activities planned for first quarter have been completed with the first tranche of USD 48,200. The CO has received second tranche of 64,200. With the second tranche, CO has planned to carry out some of the activities and an amount of USD 19,000 has been re-programmed for response to COVID-19 crisis. Guided by UNFPA internal technical guidance and instructions on the level of flexibility and possibility to manage resources from the Technical Division, the CO has prioritized the following activities for MNH with regards to COVID-19 in order to upkeep the health system functioning and maintain SRHR information and services, protect the health workers (especially the midwives) and to limit the spread of COVID-19. Proposed activities for re-allocation budget: <ul style="list-style-type: none"> - Strengthen SRH sub-cluster led by UNFPA for effective coordination | UNFPA, MHTF Reprogramming toward COVID-19, unknown year, p.2 |

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| <ul style="list-style-type: none"> - 2,000 Procurement and distribution of PPE for the protection of health workers - 15,000 Printing of awareness materials for prevention against COVID-19 2,000 Total 19,000 - Risks and Limitations: The CO has already allocated funds to the implementing partners for 2020 based on the approved budget. The reallocation will be based on the approval of APRO and UNFPA HQ as well as further discussion with the implementing partners. Procurement of PPE will be also subject to availability in the local market due to high demand and low production as well as disruption of global supply chain management. | |
| <ul style="list-style-type: none"> ● BMS undertook a range of activities during COVID-19 including supplying PPE to MWs working in 342 Upazilas of the country including PPE gowns, masks, gloves, sanitisers, face shields etc. It also provided infra-red thermometers and Doppler machines to 80 Upazilas where these were not available before. Online training was made available on donning and doffing PPE, and counselling was also made available for any MW in need. | President, Bangladesh Midwifery Society, Dhaka, Bangladesh, June 2021 |
| <ul style="list-style-type: none"> ● Once COVID-19 hit Bangladesh in March 2020, UNFPA responded by adjusting the SNMP programme to respond to the crisis. Thus, the clinical mentors became front line workers who helped in case management, triaging, infection prevention and working in special units set up for COVID-19 positive maternity patients - UNFPA provided PPE material including reusable gowns to 91 UHCs in 60 districts through his project, avoiding overlap with BMS' COVID-19-related PPE distribution - Some midwives were also provided with mobile phones for carrying out telemedicine with ANC clients | Project Director, Save the Children, Dhaka, Bangladesh, June 2021 |
| Togo | |
| <ul style="list-style-type: none"> ● PPE for health care workers and related infection prevention and control training ● Strengthen hygiene standards in targeted maternity units and support local production of hygiene products ● Referral transport for obstetric and newborn complications (with required measures in COVID-19 context) ● Life-saving commodities procurement and distribution to targeted health facilities ● Support the reorganization of health facilities and develop temporary structures to mitigate the risk of infection ● Support remote prenatal and postnatal consultations (phone based) ● Strengthened Maternal and Newborn death's notification and response. | UNFPA, COVID-19 Response Nine Countries, 2020 |
| <ul style="list-style-type: none"> ● The project was formally announced through a joint press release along with the publication of a human-interest story on UNFPA's website which was promoted on the Agency's social media channels. UNFPA also leveraged its partnership with Global Citizen as part of the Unite for Our Future digital concert to draw attention to the UNFPA-Takeda partnership. The launch of the project was marked by a ceremony and handover of PPE in each of the three target countries. In Benin, UNFPA organized a joint mission of local authorities and governments, focusing on 'the leaving no one behind agenda' with a visit to the internally displaced persons in the village of Cobly. In Togo, the event was officiated by the Minister of Health on behalf of the President, aligning with the new presidential mandate, which prioritizes maternal health care. In Guinea, fifteen health centres were equipped with PPE and critical midwifery capacity before high level officials including the Minister of Women's Rights and Empowerment and Ambassador of Japan, national authorities, and the community. UNFPA is partnering with AFP to conduct filmmaking and photography missions to the three countries to document human interest stories. Visual assets will be complemented by written stories to be developed by AFP journalists on the ground. | UNFPA and Takeda, Global CSR Progress Report, 2020 |

ANNEX 2: References

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ANNEX 3: Key informants

GLOBAL/REGIONAL

| Name | Organization | Position |
|-------------------------|---|--|
| Lynn Freedman | AMDD/Columbia University | Programme Director |
| Francine Akoueikou | Government of Benin | Country Midwifery Advisor |
| Dalya Eltayeb | Federal Ministry of Health, Sudan | Director of Primary Health Care |
| Lindsey Pollaczek | Fistula Foundation | Vice President of Programs |
| Michaela Michel-Schuldt | Government of Germany | Global Health Programmes |
| Alison Morgan | Global Financing Facility | MNH Lead |
| Nicolas Ray | Institute of Global Health, Faculty of Medicine, University of Geneva | Professor and Head of GIS/Access Programme |
| Franka Cadee | International Confederation of Midwives | President |
| Sally Pairman | International Confederation of Midwives | CEO |
| Kristonia Lockhart | Islamic Development Bank | Lead Gender Specialist/Women and Youth Empowerment Division |
| Anne Pfitzer | Jhpiego | Acting Director, Family Planning and Reproductive Health |
| Anna Af Ugglas | Laerdal Global Health | Project Manager |
| Helena Lassen | Maternity Foundation | Program Director |
| Mohamed Abdul Alim | Ministry of Health, Bangladesh | Programme Manager, Maternal Health, |
| Karolina Krywulak | Permanent Mission to the United Nations, Government of Poland | Humanitarian and Health Lead |
| Mathias Gakwerere | Government of Rwanda | SRHR Specialist |
| Mandira Paul | Government of Sweden | Maternal and SRHR Health Adviser |
| Liuchi Hara | Takeda Foundation | Corporate Social Responsibility Lead |
| Anneka Ternald Knutsson | UNFPA | Chief Sexual and Reproductive Health Branch |
| Ashkan Alavi | UNFPA | Strategic Partnership Specialist |
| Desmond Koroma | UNFPA (HQ) | Technical Advisor |
| Erin Anastasi | UNFPA (HQ) | Coordinator, Campaign to End Fistula and Technical Specialist - SRH/ Fistula |
| Geeta Lal | UNFPA (HQ) | MHTF Global Midwifery Programme Coordinator |
| Jean-Pierre Monet | UNFPA (HQ) | Technical Specialist Health System |
| Michel Brun | UNFPA (HQ) | Reproductive Health Adviser |
| Nayanesh Bhandutia | UNFPA (HQ) | Chief ITSO |

GLOBAL/REGIONAL

| Name | Organization | Position |
|-----------------------|---------------------------|--|
| Tharanga Godallage | UNFPA (HQ) | Results Based Management Adviser |
| Willibald Zeck | UNFPA (HQ) | MHTF Global Coordinator |
| Catherine Breen | UNFPA APRO | SRH/MHTF advisor |
| Mohamed Afifi | UNFPA ASRO | SRH/MHTF advisor |
| Shible Sabhani | UNFPA ASRO | Arab States Regional Office |
| Aster Berhe | UNFPA ESARO | CMA/MHTF focal person – Ethiopia |
| Muna Abdullah | UNFPA ESARO | SRH/MHTF advisor |
| Zalha Assoumana | UNFPA WCARO | SRH/MHTF advisor |
| Allisyn Moran | World Health Organisation | MNH Lead |
| Anshu Bannerjee | World Health Organisation | Director, Department of maternal, Newborn, Child and Adolescent Health |
| Sarah Barnes | Wilson Center | Project Director |
| Jenipher Mijere | Government of Zambia | CMA/MHTF focal person |
| Bridget Asiamah | UNFPA | Technical Analyst, Fistula |
| Petra ten Hoop-Bender | UNFPA | Technical Advisor, SRHR, Midwifery |

BANGLADESH – desk

| Name | Organization | Position |
|---------------------------|---|------------------------------------|
| Momtaz Begun | Bangladesh Midwifery Society | President |
| Rondi Anderson | UNFPA | International Midwifery Specialist |
| Dr Mohammed Sharif | Directorate General of Family Planning, MoH | Director |
| Rabeya Basri | Directorate General of Nursing and Midwifery | Midwifery Officer |
| Dr Shehlina Ahmed | FCDO/DFID | Advisor |
| Dr Mahbuba Khan She | WHO | National Professional Officer |
| Prof Dr Rowshan Ara Begum | The Obstetrical and Gynecological Society of Bangladesh | Past President |
| Dr Md. Khairul Alam | Save the Children | Project Director |
| Dr Md. Ziaul Matin | UNICEF | |
| Dewan Md. Emdadul Hoque | UNFPA | |
| Farita Begum | UNFPA | |

BENIN

| Name | Organization | Position |
|---|-------------------------|--|
| UNFPA – Bureau Pays | | |
| Barbara Laurenceau | UNFPA | Représentante du Bureau UNFPA Bénin |
| Alexandrine Dazogbo | UNFPA | Représentante Assistante, chargée de la coordination du programme |
| Seydou Belemvire | UNFPA | Conseiller technique, Santé reproductive et droits des adolescents et jeunes, chef de pilier SSR |
| Cyrille Agossou | UNFPA | Chef suivi-évaluation |
| Francine Akoueikou | UNFPA | Point Focal MHTF, Chargée de programme Planning familial, VIH et profession de la sage-femme |
| Wilfried Rouamba | UNFPA | Innovation and Technology Team Lead |
| Ministère de la Santé – niveau National | | |
| Thierry Lawale | Ministère de la Santé | DG /ANSSP |
| Mabou Ahokossi | Ministère de la Santé | Directeur de la protection mère-enfant |
| Iarisse Agonglo | Ministère de la Santé | Directrice des soins infirmiers et obstétricaux |
| Ghislain Hollo | Ministère de la Santé | Chef service des ressources humaine |
| Ministère de la Santé – niveau départemental/zones de santé et centres de santé | | |
| Lambert Loko | Ministère de la Santé | Directeur General/CHU-MEL / Littoral |
| Murielle Abiassi | Ministère de la Santé | Sage-femme Responsable maternité CHU-MEL |
| Victor Cocouvi | Ministère de la Santé | DDS/ Atlantique |
| Ibrahim Gouda | Ministère de la Santé | Coordonnateur zone sanitaire Parakou-Ndali : Borgou |
| Souleymane Kouri | Ministère de la Santé | Médecin Chef centre de santé TOUROU |
| Diane Onibon | Ministère de la Santé | Sage-femme maternité TOUROU |
| | Ministère de la Santé | Sage-femme maternité MISSESSIN |
| Dolorès Hounyeme | Ministère de la Santé | Sage-femme maternité TANGBO DJEVIE / Atlantique |
| Mr Lambert Loko Mme Kouenassi | Ministère de la Santé | CHU MEL SF/nutritionniste – surveillante générale hôpital |
| Utilisatrices de services | | |
| Focus group discussions avec 7 patientes | Maternité TANGBO DJEVIE | |
| Focus group discussions avec 10 patientes | Maternité TOUROU | |

BENIN

| Name | Organization | Position |
|--|--|--|
| Focus group discussions avec 7 patientes | Maternité MISSESSIN | |
| Société civile : ONGs, associations professionnelles | | |
| Pulchérie Achade | OSV Jordan | Directrice Adjointe |
| Christèle Boyi | CERRHUD | Chargée de programme |
| Jérôme Chatigre | GRAFED | Directeur exécutif |
| Philomène Sansuamon | Ordre National des SF du Bénin | Présidente |
| Laurence Monteiro | Association nationale des SF du Bénin | Présidente |
| Emery Nkunziza | ABMS/PSI | Directeur pays |
| Yollande Aguidissou | Plan International BENIN | Chef programme santé |
| Ecoles de Sages-Femmes : Responsables et élèves | | |
| Christiane T. Aguemon | Ecole des Sages-femmes Cotonou | Directrice |
| Francis Tognon Tchegnonsi | Institut form. soins infirm. et obstétricaux - Parakou | Directeur |
| Kabibou Salifou | Ecole sup. des Sages-femmes d'Etat - Parakou | Directeur |
| Elèves sages-femmes de 2ème année – Parakou (5 participants) | Ecole des SF Parakou | |
| Elèves sages-femmes de 3ème année – Cotonou (6 participants) | Ecole des Sages-femmes Cotonou | |
| Partenaires techniques et financiers | | |
| Mieke Vogels | Ambassade des Pays-Bas | Conseillère SDRS |
| Bertille A. Onambele | USAID | Chargée de programme santé |
| Mathias Finoude | Ambassade du Canada | Assistant technique santé |
| Zenab Konkobo Kouanda | Banque Mondiale | Spécialiste de santé publique, banque Mondiale Bénin |
| Thierry Tossou Bocco | OMS | Chargé de programme Santé Maternelle et Infantile |

SUDAN

| Name of informants | Organization | Position |
|-------------------------|--|-----------------------|
| Esmehan Elkhair Babekir | Federal Ministry of Health Khartoum City | MCH director |
| Iman Hajo Ibrahim | Federal Ministry of Health Khartoum City | RH director |
| Amel Mohamed | Federal Ministry of Health Khartoum City | Midwifery focal point |
| Huda Farah | Federal Ministry of Health Khartoum City | Fistula focal person |
| Amani Mohamed Ahmed | Federal Ministry of Health Khartoum City | EmONC focal person |

SUDAN

| Name of informants | Organization | Position |
|---------------------------------------|---|---|
| Mawada Mohamed Ali | Federal Ministry of Health Khartoum City | NRHP Supplies |
| Mawahib Alfadul | Federal Ministry of Health Khartoum City | NRHP / M&E officer |
| Elaf Ali | Federal Ministry of Health Khartoum City | Family planning focal point |
| Walaa Mahjoub | Federal Ministry of Health Khartoum City | RH cancer focal point |
| Dr Dalya Eltayeb | Federal Ministry of Health Khartoum City | PHC Director |
| Dr Mateen Shaheen | UNFPA Country Office Khartoum City | Country Deputy Representative |
| Dr Majid Alameen Elnour | UNFPA Country Office Khartoum City | RH Coordinator –FMoH focal point |
| Dr Sulafa Satti | UNFPA Country Office Khartoum City | RH Analyst- MISP focal point |
| Dr Sarah Abas | UNFPA Country Office Khartoum City | RH Advocate – Midwifery focal point |
| Dr Rania Hassan | UNFPA Country Office Khartoum City | PHC Coordinator |
| Dr Mohammed Ahmed Sidahmed | UNFPA Country Office Khartoum City | Assistant Representative |
| Dr Sawsan Eltahir | UNICEF Country Office Khartoum City | MNH Coordinator |
| Dr Maison Elameen | World Health Organization Khartoum City | Women’s SRHR and GBV focal point – MCH Directorate |
| Dr Osama Alnour | Academy of Health Sciences Khartoum State | General Director |
| Yassir Ibrahim Awad | CAFA (Community Animator Friendly Association), Khartoum City | SRH/HIV Projects Manager |
| Dr Khalid Abdulla Tahir | Omdurman Maternity Hospital Khartoum State | Recent General director |
| Dr Imad Abd Almonem Alkhair Altaib | Omdurman Maternity Hospital Khartoum State | Previous General director |
| Amna Awad Edeid | Omdurman Maternity Hospital Khartoum State | Health Provider-Nurse midwives |
| Unnamed | Omdurman Maternity Hospital Khartoum State | Client/ Community member |
| Dr Nuha Sulaiman | Hay Alzour Primary Health Care Centre, Khartoum State | General Director and Health Provider |
| Dr Waleed Alnour Mohammed Daif | Aldamazin Hospital Blue Nile State | General Medical Director |
| Kateera Ibrahim Ahmed | Aldamazin Hospital Blue Nile State | Health provider- Nurse midwives |
| Unnamed | Aldamazin Hospital Blue Nile State | Client/ Community member |
| Dr Sawsan Omer Fadul | State Ministry of Health | PHC Director |

SUDAN

| Name of informants | Organization | Position |
|---------------------------|---|--------------------------|
| | Blue Nile State | |
| Hanan Khamees Akock | State Ministry of Health Blue Nile State | RH Director |
| Intisar Altoum Dafa Allah | State Ministry of Health Blue Nile State | Child Health Coordinator |
| Omar Alaees Mussa | CAFA (Community Animator Friendly Association), Blue Nile State | Director |

TOGO – desk

| Name | Organization | Position |
|--|---|--|
| AGBIGBI Yawo | UNFPA | Chargé Programme SR |
| Dr Bwato Nsindi | UNFPA | |
| M. ABALO Komi | UNICEF | Spécialiste VIH/Sida et point focal MUSKOKA |
| Dr TCHANDANA Makilioubè | DSMI/PF | Chef division |
| Mme D'ALMEIDA ADANDOGOU | Association des Sages-Femmes du Togo | Présidente |
| Mme Etorh | Hôpital du district de Zio | Sage-femme d'état |
| Mme Mensah | Hôpital de district de Zio | Point focal SR |
| Sage-femme pour CPN | Hôpital de district de Zio | Sage-femme pour CPN |
| Six femmes ayant accouché et ayant bénéficié de SONUB | Hôpital du district de Zio | Membres de la communauté |
| Six femmes en CPN | Hôpital du district de Zio | Membres de la communauté |

UGANDA

| Name | Organization | Position |
|----------------------|-----------------------------|--|
| Dr Mugani | Ministry of Health, Kampala | Assistant Commissioner Reproductive and Infant Health |
| Dr Robert Mutumba | Ministry of Health, Kampala | Principle Medical Officer |
| Emily Bako | Ministry of Health, Kampala | Principle Nursing Officer |
| Wilberforce Mygwanya | Ministry of Health, Kampala | UNFPA secondment to MoH for M&E – RH and Infant Health |
| Dr Lawrence Kazibwe | Ministry of Health, Kampala | Director, Kawempe National Referral Hospital |

| | | |
|------------------------------------|--|--|
| Dr Safina Musene | MoES, Kampala | Commissioner, Business, Technical, Vocational Education and Training |
| Tina Makimera | MoES, Kampala | Responsible for education of health cadres |
| Martin Opolot | Uganda Midwives & Nurses Council | IT Specialist |
| Alain Siebenaler | UNFPA CO, Kampala | Country Representative |
| Dr Edson Muhwezi | UNFPA CO, Kampala | Assistant Representative |
| Christine Kajungu | UNFPA CO, Kampala | Programme Specialist – MH |
| Maria Najjemba | UNFPA CO, Kampala | Programme Analyst – MH |
| Richard Mwesigwa | UNFPA CO, Kampala | MNCH/Fistula Focal Point |
| Rosemary Kindyomunda | UNFPA CO, Kampala | SRHR Integration Focal Point |
| Grace Myerwanire Murindwa | World Bank, Kampala | Technical Advisor/GFF Focal Point |
| Charity [need last name] | SIDA, Sweden Embassy, Kampala | Acting PO SRHR, Democracy and Human Rights |
| Judith Adokorach | Netherlands Embassy | Policy Officer, SRHR |
| Alice | Terrewode | unknown |
| Cindarella Anena | UNFPA field office for West Nile and Acholi Subregions, Lawmo district | Field Coordinator |
| Grace Anena | Ministry of Health, Gulu District | Assistant DHO/RMNCAH |
| Dr Denis Ochoula | Ministry of Health, Lawmo District | DHO |
| Takish Oroma | Ministry of health, Lawmo District | Assistant DHO/MCH |
| Christine Birabwa | Project Officer for Quality Assurance, Arua, West Nile | Marie Stopes Uganda |
| Polly Akot | St Mary Midwifery School Kalongo, Agago District, Acholi | Deputy Principal |
| Helen Alobogwal | St Mary Midwifery School Kalongo, Agago District, Acholi | Senior Nursing Officer |
| Ruth Awor | St Mary Midwifery School Kalongo, Agago District, Acholi | Health Tutor |
| Dr Florence Nalubega | St. Joseph Kitovu Hospital Masala District, Western Uganda | Fistula surgeon |
| Sister Dr. Nabukalu Anthony Imelda | St Joseph Kitovu Masala District, Western Uganda | Director of Fistula Programme |

ZAMBIA

| Name | Organization | Position |
|-----------------|----------------------------|--------------------------------|
| Dr Angel Mwiche | Ministry of Health, Lusaka | Deputy Director, Public Health |
| Caren Chizuni | Ministry of Health, Lusaka | Chief Safe Motherhood Officer |

| | | |
|-------------------|---|-----------------------------------|
| Daphen Shamambo | Ministry of Health, Lusaka | Chief Nursing Officer (Training) |
| Ruth Bwepe | Ministry of Health, Lusaka | Family Planning Programme Officer |
| Toddy Sinkamba | General Nursing and Midwifery Council of Zambia, Lusaka | Director, Education and Training |
| Dr Goshon Kasanda | Ministry of Health, Lusaka | Fistula surgeon |
| Gift Malunga | UNFPA Zambia, Lusaka | Country Representative |
| Leonard Kamugisha | UNFPA Zambia, Lusaka | Assistant Country Representative |
| Dr Wezi Kaonga | UNFPA Zambia, Lusaka | Programme Specialist, SRH |
| Elizabeth Kalunga | UNFPA Zambia, Lusaka | Programme Coordinator |
| Jenipher Mijere | UNFPA Zambia, Lusaka | Fistula Analyst |
| Dr Rodgers Mwale | UNICEF, Lusaka | Health Specialist |
| Sarah Ngoma | Midwifery Association of Zambia, Lusaka | President |
| James Mdala | Marie Stopes Zambia, Lusaka | Programme Officer |
| Jully Chilambwe | JHPIEGO, Lusaka | Health Advisor, MNCH |
| Alice Chembe | Planned Parenthood of Zambia, Lusaka | Programme Officer |
| Betty Kunda | Catholic Relief Services | MNH Technical Advisor |
| Miriam Mwiinga | Young Women's Christian Association (YWCA) | Programme Officer |
| Rosemary Mwanza | Lewanika Midwifery School, Mongu, Western Province | Principal Tutor |
| Danny Mulembwe | Ministry of Health, Luapula Province | Principal Nursing Officer |
| Catherin Matyola | Ministry of Health, Western Province | Principle Nursing Officer |

ANNEX 4: Global and country level interview protocols

Global Key informant questionnaire

Introductory note

Thank you for agreeing to participate in this evaluation of the UNFPA Maternal and Newborn Health Thematic Fund. Your comments will be confidential, and we will not attribute to you any remarks you make without your permission. The interview is arranged around a number of open questions using a semi-structured approach. If recording the interview, seek consent now and tick the box below].

1. Name of key informant:
 2. Organisation:
 3. Title or role:
 4. Date interviewed:
 5. Country:
 6. Type of organization:
 - a) UNFPA
 - b) Other United Nations Organisation
 - c) Multilateral or Bilateral Development Agency or foundation
 - d) National Health Authority or other Ministry or Agency of Government
 - e) International Non-Governmental Organization (iNGO) or its national Affiliate
 - f) National/Local NGO or Community-Based Organisation (CSO)
 - g) Other (please specify)
 7. Consent to record sought? Y/N
 8. Consent to record given? Y/N
-

General questions to all key informants

1. Thinking about the **global context of maternal and newborn health**, what are the **key issues that stand out** to you in the current context?

Probe: If COVID is the major issue, probe about the issues prior to and moving on from COVID as well.

2. For maternal and newborn health going forward, what are the **major challenges and opportunities** for countries and global partners?
3. Which **partners are the main drivers of maternal and newborn health** currently (**Note:** these may not be health factors – they could be nutrition, poverty reduction, systems strengthening etc.)? What role has UNFPA played in that context both before and since COVID? What is the overall contribution of UNFPA generally to the MNH landscape in your view?
4. What are the strong points or **value-added of the MHTF as a partner in maternal and newborn health**? What does it do that is ‘additional’ in this area?
5. How could **MHTF add more value**? How could UNFPA strengthen its contribution to MNH and SRHR in your country?

6. Do you have a sense of the MHTF as an **agent for catalytic action**? If yes, how and with what examples? If no, why do you think that is? How and to what extent do you think UNFPA fosters, identifies, and supports the implementation of innovations and good practices within and among countries.
7. MHTF works to support **integration, equity and quality**: is this noticeable to you? Do you have comments on this orientation and how well they perform?
8. To what extent do you think the UNFPA's approach to **addressing/ responding to COVID-19** has been particularly innovative, helpful, gap-filling, in other ways critical to preserving maternal and newborn health gains in the poorest countries?
9. How and to what extent do you think UNFPA plays an important **convening role** to forge partnerships, coordinate approaches and strategies, and mobilise resources to advance MNH.
10. Please provide examples of UNFPA **leadership** to advance MNH strategies, programmes, and best practices.

For Midwifery specialists

11. Please talk about your view of UNFPA MHTF investments into advancing midwifery at global, regional and country levels.

For example, have MHTF inputs/ support strengthened education, professional standards, the capacity of midwifery organisations, in-service training etc.?

For Referral and EmONC specialists

12. How and to what extent has UNFPA effectively supported national strategies and plans to support a well-defined and functioning national network of EmONC facilities including quality enhancement, tools and data, access to services, the availability and performance of skilled birth attendants and clearly integrated services (MNH and SRHR).

For MPDSR specialists

13. How and to what extent has UNFPA support and investment led to the establishment and scale-up of evidence-based Maternal and Perinatal Death Surveillance and Response (MPDSR) in your region or country including more regular, better quality death audits that lead to timely notification, better action taken by health providers and/ or communities, specific improvements in maternal care,

For Fistula and other obstetric emergencies specialists

14. How and to what extent has UNFPA supported strengthening government capacity to develop, implement and monitor costed and time-bound national strategies for prevention, treatment and recovery from fistula, leading to improved capacity and delivery at all stages (prevention, diagnosis, repair, and recovery/ reintegration).

Please provide examples of UNFPA efforts as a broker to facilitate effective partnerships and multi-stakeholder participation for a well-coordinated fistula response. Please also describe any gaps or missed opportunities.

Final question: 15. Is there anything further to add? Other observations or comments?

Thank you for your time!

Country Case Study Interview Guide – Part I: National Level Stakeholders

Instructions on how to use the guide

The guide is not a questionnaire but rather a set of questions/discussion topics with accompanying prompts. The sub-questions serve as reminders which can be used to probe for more detail when the response to the overall question fails to cover an area highlighted by one or more sub-questions.

The guide is intended for interviews with national level stakeholders with an understanding of the overall landscape of MNH and SRHR in the country, such as UNFPA staff, national health authorities, development partners and implementation partners, etc. Feel free to skip questions related to a particular technical area if the KI does not have specific knowledge of the topic (i.e., on midwifery, EmONC, MPDSR and/or fistula).

Note: Please note that many stakeholders do not distinguish between MHTF activities and those supported more broadly by UNFPA with other funding. Therefore, you may want to refer to UNFPA rather than MHTF during interviews.

Introduction

Thank you for agreeing to participate in this evaluation of the UNFPA Maternal and Newborn Health Thematic Fund. Your comments will be confidential, and we will not attribute to you any remarks you make without your permission. The interview is arranged around a number of open questions using a semi-structured approach. [If recording the interview, seek consent now and tick the box below].

9. Name of key informant:
 10. Organisation:
 11. Title or role:
 12. Date interviewed:
 13. Country:
 14. Type of organization:
 - h) UNFPA
 - i) Other United Nations Organisation
 - j) Multilateral or Bilateral Development Agency or foundation
 - k) National Health Authority or other Ministry or Agency of Government
 - l) International Non-Governmental Organization (iNGO) or its national Affiliate
 - m) National/Local NGO or Community-Based Organisation (CSO)
 - n) Other (please specify)
 15. Consent to record sought? Y/N
 16. Consent to record given? Y/N
-

General

15. How would you describe the overall **context of maternal and newborn health in [country]**?
 - a. What are the key issues that stand out to you in the current context?
 - b. What factors influence maternal and newborn health most clearly (see Table at end of questionnaire for types of issues that affect access by women, newborns and adolescents to health services).

Probe: If COVID is the major issue, probe about the issues prior to and moving on from COVID as well.

16. Thinking about these priorities, what role does the UNFPA (through the MHTF) play in this context and what specific objectives or areas of focus have been identified for the MHTF?

Probe: Why are these areas the MHTF focus? Was it a specific gap or was there demand from the country? Or was it suggested by MHTF itself as what they could offer?

MHTF Technical Focus

For this part of the interview, I would like to discuss your views on some of the most important operational aspects of MNCH these are midwifery, EmONC, MPDSR, and Fistula and other obstetric emergencies.

Midwifery

17. Has UNFPA contributed to an **enabling policy and regulatory environment** for midwives in [country]? How/by what means)? Probe regarding the effectiveness of UNFPA leadership to advance the following:
 - a. Policies, strategies and plans for recruiting, deploying and retaining midwives
 - b. Regulatory bodies that govern midwifery practice, certification, accreditation, monitoring and accountability
 - c. Supportive supervision policies, guidelines and standards
18. Has UNFPA contributed to **strengthening midwifery education programmes** (pre-service and in-service) in {country}? If yes, how?
 - a. Probe for examples of efforts to strengthen number and capacity of midwifery schools, standardized competency-based education programmes, alignment with global standards (e.g., ICM)
19. How has UNFPA worked to **strengthen the capacity of midwifery organizations**? How effective are these efforts (i.e., in terms of increased opportunities for **continuous professional education**, support for **young midwife leaders**, **sustainability** of capacity)?

EmONC

20. What is the **status of EmONC services** in [country]?
 - a. Is there a national strategy in support of a well-defined network of facilities that meet quality standards?
 - b. What are the key issues and challenges?
21. How and to what extent has **UNFPA supported improved coordination and monitoring of EmONC services**? (Probe areas of technical support, including **advocacy and policy dialogue, quality improvement, tools and data collection, access to services, and integration of MNH and SRHR**).
 - a. Probe whether other partners are engaged and effectiveness of UNFPA leadership to coordinate efforts.
22. How and to what extent has UNFPA supported **capacity of skilled birth attendants** in EmONC facilities?
 - a. How effective are capacity development efforts in improving performance of skilled birth attendants?

MPDSR

23. What is the status of the **Maternal and Perinatal Death Surveillance and Response (MPDSR)** programme in [country]?
 - a. What are some key issues and challenges with regard to implementation, scale-up?
24. How and to what extent has **UNFPA contributed to the MPDSR** programme? By what means?

- a. Examples of inputs, i.e., advocacy and policy dialogue, coordination and capacity building in MPDSR process, multi-stakeholder participation
- b. Examples of outputs, i.e., improved procedures, review and audit practices; actionable and verifiable death audits; timely reporting and follow-up; implementation of findings
- c. What has been the impact/consequences of MPDSR efforts (credibility of process, utilization of findings, improved quality of care?)

Fistula and other obstetric emergencies specialists

25. What has UNFPA done to **strengthen government leadership and capacity** at national and sub-national levels to support national fistula strategy development, implementation and monitoring across the four dimensions of fistula prevention, diagnosis, treatment and recovery/reintegration? Probe for examples of:
 - a. Policy dialogue, advocacy and communications
 - b. TA for costed national strategies
 - c. Technical guidance to support training, repair, rehabilitation
26. What other partners are engaged in fistula? How has UNFPA helped to **facilitate effective, multi-stakeholder partnerships for a coordinated fistula response?** (Include UNFPA leadership in **Campaign to End Fistula** platform)
27. What **gaps or opportunities** remain?

MHTF Strategies and Approaches:

The next few questions are concerned with different strategies and approaches used by UNFPA to support MNCH.

Integration of MNH and SRHR

28. What has been the role of UNFPA in supporting strategies and other national platforms to strengthen integration (such as UHC, GFF investment cases, Costed Implementation Plans, etc.) or via programme models (such as PFPF, PAC, safe abortion services (where legal), PMTCT)?

Equitable and Accountable Access

29. What has UNFPA done to support national authorities to **focus increased attention and financial resources to equitably address** the needs of women, newborns and adolescents, including the vulnerable and disadvantaged?

Catalytic Role

30. What **role has UNFPA played** to advance maternal and newborn health within the broader MNH and SRHR landscape in your country, both before and since COVID? How would you describe its **comparative advantage** to coordinate partnerships and leverage funding? Are there examples of how UNFPA has introduced, fostered or scaled up innovations or lessons learned?

MHTF Governance and Management (for UNFPA staff only):

31. How has MHTF worked as a mechanism within UNFPA to foster effective and efficient coordination of programmes and prioritization of financial and human resources, including for resource mobilization for MNH and SRHR?
32. How has the country programme benefited from MHTF support in [country]? How might this be improved going forward?

COVID-19

33. What has UNFPA done in [country] to **respond and adapt to COVID-19**, such as:
 - a. **Policies** and programme adjustments

- b. **Reallocation of funding/reprogramming**
- c. **Mobilisation of additional funds** at country or regional level specifically to address MNH and SRHR challenges related to COVID?
- d. Participation by UNFPA to **assess the impact of COVID** on women and adolescents and **identify critical needs** for support

General/Wrap-up

34. What are the strong points or **value-added of the UNFPA as a partner in maternal and newborn health**? What does it do that is ‘additional’ in this area?

35. How could UNFPA **strengthen its contribution to MNH and SRHR** in your country?

Final question

36. Is there anything further to add? Other observations or comments or examples? Documents or other material to pass on?

Table 1: Examples of factors that affect access to health services for women, adolescents and babies

| Supply-side factors | Demand-side factors | Social and economic determinants and vulnerabilities |
|--|---|---|
| <ul style="list-style-type: none"> ● Availability of services, open when needed and within reach, including sexual and reproductive health services such as family planning, ANC, delivery services, and post-natal care and nutrition counselling ● Quality of care including available, motivated, trained, skilled, and well-managed staff ● Availability of essential commodities including contraception, antibiotics, life-saving maternal health medicines ● Political commitment to improving health and increasing public financing for health ● Accountability across the health system ● Community engagement and participation for health management | <ul style="list-style-type: none"> ● Access barriers based on costs including the direct costs of care (fees for services, diagnostic tests and medicines) and the costs of accessing care (childcare, foregone labour) ● Lack of permission from family members (spouse for example) to seek care ● Distance to services and/or lack of transport; costs of transport ● Lack of knowledge about the benefits of specific services, stigma, fear, language and other barriers ● Cultural preferences that favour local solutions (traditional medicine, home births) ● Lack of trust in health services (bad prior experience, unkind health workers) | <ul style="list-style-type: none"> ● Multidimensional poverty increases the likelihood of harmful behaviours and practices including child marriage, increased risk of adolescent pregnancies, SGBV and other vulnerabilities ● Lack of education in girls and women ● Gender barriers and lack of legal rights for women and girls ● Lack of economic empowerment of women and girls with associated limited employment opportunities and control over household income ● Nutritional insecurity combined with poor water and sanitation ● Living in high density urban areas or in remote geographies ● Those caught up in conflict and insecurity |

Country Case Study Interview Guide – Part II: Stakeholders engaged in MNH and SRHR service delivery

Instructions on how to use the guide

The guide is not a questionnaire but rather a set of questions/discussion topics with accompanying prompts. The sub-questions serve as reminders which can be used to probe for more detail when the response to the overall question fails to cover an area highlighted by one or more sub-questions.

The guide is intended for interviews with key informants working at the service level, either in the direct delivery of services and/or as a supervisor at the provincial, district or institutional level. Feel free to skip questions related to a particular technical area if the KI does not have specific knowledge of the topic (i.e., on midwifery, EmONC, MPDSR and/or fistula).

Introduction

Thank you for agreeing to participate in this evaluation of the UNFPA MHTF. Your comments will be confidential, and we will not attribute to you any remarks you make without your permission. The interview is arranged around a number of open questions using a semi-structured approach. [If recording the interview, seek consent now and tick the box below].

1. Name of key informant:
2. Organisation:
3. Title or role:
4. Date interviewed:
5. Country:
6. Name of health facility:
7. Type of health facility:
8. Name of District/Province:
9. Consent to record sought? Y/N
10. Consent to record given? Y/N

-
1. What **SRMNH services** are offered by this facility (on-site or community based)?
 2. What is your **role in SRMNH services**; how long have you been working in this facility?
 3. What are the **biggest issues you face in delivering SRMNH services** in your facility/district/province?

Probe: If COVID is the major issue, probe about the issues prior to and moving on from COVID as well.

4. What **role, if any, does the UNFPA (through the MHTF)** play in supporting your facility/district/province in SRMNH?
5. What are the **areas of technical focus supported by UNFPA**? Probe for EmONC, midwifery, MPDSR, fistula and other areas.
6. What **other partners are assisting you in addressing SRMNH** service delivery? How well is this assistance coordinated among the various partners supporting your facility/district/province?
7. **For district/provincial managers only:** Please describe any **training/capacity development related to the management** of SRMNH service delivery, such as **CQI, supervision and mentoring approaches**.
8. Please describe any **training related to SRMNH services** you or your colleagues may have received in the past three years.

9. How did this training support you?
 - a. What specific areas of learning were most important to you?
 - b. How did the way you provided services change as a result of your training? Please give examples.

10. What **other inputs were provided to the facility [or facilities if district level]** to improve the delivery of SRMNH services?
11. How are **health care providers supervised and/or mentored** at this facility **[or facilities if district level]**? How has this changed over time?
12. What **systems or approaches do you use to improve quality of care**? How are services monitored to ensure quality and rights? [Probe for monitoring of equity, accountability and dignity/respectful care]
 - a. How has quality changed over time?
 - b. Do you get feedback on clients' experiences of service delivery? If yes, how is this information used?
13. Has your health facility **[or district/region]** changed the way it **collects and uses data for decision-making**? How and when have these changes been made?
14. Is the **MPDSR process** conducted at this facility **[or facilities if district level]**?
 - a. Describe the process, including how it is supported at district/provincial level.
 - b. What have been the trends in notification of deaths (increase, decrease, the same)?
 - c. Who participates in the review?
 - d. Have findings been used to support improvements? If so, how (provide examples)?
15. What efforts are being undertaken to **prevent, diagnose and refer women with obstetric fistula** or other obstetric morbidities?
 - a. **Primary measures** (i.e., health promotion, planned pregnancies, contraception, community awareness)
 - b. **Secondary measures** (i.e., antenatal care, skilled birth attendants, use of partograph, identification of signs/symptoms of obstructed labour, immediate referral, bladder care/catherization)
 - c. **Tertiary prevention** (i.e., access to EmONC and safe C-sections, use of indwelling catheter).
16. **For sites performing fistula repair:**
 - a. **Prevention:** What approaches have yielded the best results in **identifying women** with fistula? In your view what are the **most significant gaps** that need to be addressed to eradicate fistula?
 - b. **Access/equity:**
 - How are women supported who are **unable to pay for or easily access** services?
 - c. **Treatment:**
 - How many **surgeries are done annually** at your facility? What have been trends over time for past 3 years (fistula repairs, fistula-related procedures (i.e., incontinence repair, genital reconstruction)?
 - Are services offered **routinely** (when a client needs service) or during specific focused periods ("**camps**")?
 - Who performs surgery? How are your **surgeons certified**?
 - How is **quality monitored and measured**? Who oversees quality? What checklists or safe-surgery tools are used?
 - d. **Reintegration:**
 - What **kind of reintegration services** are currently provided to women after fistula repair?

- What is done to help women who are **not cured** after surgery?
 - How does the facility **keep in touch** with women treated for fistula?
 - In your experience, what **reintegration approaches** have had good results (at facility and/or community level)?
17. What is being done to **strengthen integration of MNH and SRH services**? How has UNFPA (or other partners) supported integration efforts? Please provide examples.
[Probe about any efforts to introduce or expand postpartum family planning, postabortion care, safe abortion services (where legal), and/or PMTCT.]
18. What is being done [*at your facility/district/region*] to ensure services **equitably address** the diverse needs of women, newborns and adolescents, including the **vulnerable and disadvantaged**? How are these efforts supported, and by whom?
19. What has been done by your facility/institution to **respond and adapt to COVID-19**, such as: **Policies** and programme adjustments
- a. **Reallocation** of funding/reprogramming
 - b. **Mobilisation of additional funds** at country or regional level specifically to address MNH and SRHR challenges related to COVID?
 - c. Research to **assess the impact of COVID** on women and adolescents and **identify critical needs** for support
20. Is there anything further to add? Other observations or comments or examples? Documents or other material to pass on?

Country Case Study Interview Guide – Part III: Women and adolescent community members

Instructions on how to use the guide

The guide is intended for group interviews with women regarding MNH and SRH services in their community, generally organized in the catchment area of a particular health facility which has received financial or technical assistance from UNFPA via the MHTF.

In setting up the interviews with UNFPA counterparts, explore the possibility of having distinct groups with the following characteristics, depending on the type of activities UNFPA conducts in the district/facility/community and what is logistically possible.

- Women who have consulted for routine SRMNH services
 - Adolescents (ages 15-19)
 - Women (ages 20-49)
- Women who have received EmONC services
- Women who have received fistula services

The discussion should be conducted in the local language of the community.

Introduction

Thank you for agreeing to participate in this evaluation of the UNFPA Maternal and Newborn Health Thematic Fund. Your comments will be confidential, and we will not attribute to you any remarks you make without your permission. [If recording the interview, seek consent now and tick the box below].

1. Name of catchment area:
 2. Name of District/Province:
 3. Name of health facility:
 4. Type of health facility:
 5. No. of respondents:
 6. Type of respondents:
 7. Date interviewed:
 8. Interviewer:
 9. Consent to record sought? Y/N
 10. Consent to record given? Y/N
-

21. What are the reasons you typically go see a health care provider? Do you see providers at the facility? In the community (community-based)?
22. How do you learn about ways to improve reproductive, maternal and child health in this community?
23. How were you informed about your last visit to the health provider/facility? [Probe: a friend, a community worker, poster or other media]
24. Ask the women to narrate a typical story of seeking maternal or reproductive health service, i.e., for antenatal care, reproductive health/FP, labour and delivery (including EmONC), postnatal follow-up). Consider your last visit or imagine a typical visit and tell us:
 - a. How easy was it to organize the trip to the provider/facility?
 - b. Were there any barriers you had to overcome? [Probe for access barriers: time, cost, transportation, distance, husband approval, etc.]

- c. Did you make an appointment? Just show up?
 - d. How long did it take to be seen? [Probe whether this wait was acceptable or not.]
 - e. Once in the clinic, what else happened? Describe the process, how you felt along the way, what happened throughout the visit to the end.
25. If not covered by under Question 4, ask for reflections on how they were treated during the visit.
[Probe for the following:]
- a. Privacy/confidentiality concerns
 - b. Treatment by the staff (i.e., respected your opinions; took your concerns seriously; experienced negative or biased attitudes about you)
 - c. Denial of services (if denied, for what reason)
 - d. Provision of unwanted services (be specific)
 - e. Quality of information provided i.e., about treatment provided; clear instructions, including for follow-up care; opportunity to ask and have questions answered
 - f. Did you encounter any language problems?
26. For women who came for ANC or PNC, did the provider ask any questions about family planning, the importance of healthy spacing and timing of births, and contraception; or other concerns such as HIV/STI prevention, GBV screening, etc.?
27. Did the facility meet all your needs?
- a. If your provider referred you to someone else, how was that done? Did you have any issues with the referral?
 - b. If you have been coming to this facility for many years, have you noticed any changes? What are the changes and why? Have things improved? Declined?
28. What, if anything, can be done to improve your interaction with staff and the services you receive – both at the facility and in the community?
29. Is there anything further to add regarding your experiences?

Additional Questions for Fistula clients:

30. How did you find out about the availability of treatment for fistula?
31. What were the main barriers you had to overcome to get treatment for fistula?
Based on your experience, if you met another woman with fistula in your community, what advice would you give her on seeking care?
32. Following repair, what follow-up services were offered to you?
33. What makes women's return to normal life easy or difficult here?
34. What can be done to improve the situation of women with fistula?

Facility check-list

| | | | |
|---|-----------------|---|-----------------|
| A) FACILITY and INFRASTRUCTURE | | | |
| Province: | | Name of Facility: | |
| District: | | Type of facility (circle answer): BEmONC Y / N CEmONC : Y / N | |
| Is the facility open and staffed with skilled health personnel 24h/day, 7 days/week? Yes / No | | | |
| Basic Infrastructure/sanitation (circle answer): | | | |
| Running water: | Yes / No | Lighting: | Yes / No |
| Toilet facilities: | Yes / No | Soap/disinfectant: | Yes / No |
| Comments: | | | |

B) SERVICES

| BASIC EMERGENCY OBSTETRIC AND NEONATAL CARE (SIGNAL FUNCTIONS) | | |
|---|--|---|
| Item | Performed in the past 3 months? | If not performed in past 3 months, why? (circle answer) |
| a) Administer parenteral antibiotics | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |
| b) Administer uterotonic drugs (i.e. parenteral oxytocin) | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |
| c) Administer parenteral anticonvulsants for pre-eclampsia and eclampsia (i.e. magnesium sulfate) | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |
| d) Perform manual removal of placenta | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |
| e) Perform removal of retained products (e.g. manual vacuum aspiration, dilation or curettage) | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |

| | | |
|---|---------------------------------------|---|
| f) Perform assisted vaginal delivery (e.g. vacuum extraction, forceps delivery) | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |
| g) Perform newborn resuscitation (e.g. with bag and mask) | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |
| h) Routine use of partogram for labor management | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |
| General comments: | | |
| ADDITIONAL SIGNAL FUNCTIONS FOR COMPREHENSIVE EMERGENCY OBSTETRIC CARE | | |
| Item | Performed in the past 3 months | If not performed in past 3 months, why? |
| i) Perform blood transfusion | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |
| j) Perform surgery (e.g. caesarean section) | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. Policy issues 5. No indication 6. Other reason (please specify): |
| k) Fistula repair | No Yes | 1. Training issues 2. Supplies, equipment, drugs issue 3. Management issue 4. No indication (no need) 5. Other reason (please specify): |
| General comments: | | |
| ADOLESCENT CARE | | |
| Item | Number or Y/N | Comment |
| l) Adolescent-friendly IEC materials available | No Yes | |
| m) Contraceptives offered to adolescents <u>including postpartum</u> contraception offered to adolescents | No Yes | |
| n) <u>Post-abortion</u> care and contraception offered to adolescents | No Yes | |
| o) HIV diagnostics offered to adolescents | No Yes | |

General comments:

| 3) Availability of LIFE SAVING MOTHER and NEWBORN COMMODITIES | | | | | | |
|---|---|-----------------------|----|----------------------|--|---------|
| No. | Item | Available at facility | | Stock-out? | | |
| | | Yes | No | Within last 3 months | | Comment |
| Maternal health | | | | | | |
| | Oxytocin | | | | | |
| | Misoprostol | | | | | |
| | Magnesium sulphate | | | | | |
| Newborn health | | | | | | |
| | Injectable antibiotics | | | | | |
| | Antenatal corticosteroids (Dexamethasone) | | | | | |
| | Chlorhexidine/ umbilical cleaning | | | | | |
| | Resuscitation equipment | | | | | |
| Family planning | | | | | | |
| | Condoms (female) | | | | | |
| | Condoms (male) | | | | | |
| | Emergency contraceptives | | | | | |
| | Injectable contraception | | | | | |
| | Oral Contraceptives | | | | | |
| | Implants | | | | | |
| | IUDs | | | | | |
| | Other | | | | | |
| General comments: | | | | | | |

| HMIS | | |
|--|---------------|----------|
| Item | Number or Y/N | Comment: |
| Are you capturing HMIS locally using DHIS2? | No Yes | |
| If yes, are you analyzing and using data for decision making | No Yes | |
| If yes, please provide examples of decisions you have made recently using data | | |
| If DHIS2 is not working, why? | No Yes | |

References:

World Health Organization, *Service availability and readiness assessment (SARA): An annual monitoring system for service delivery, Reference Manual*, Geneva, 2015

World Health Organization, *Monitoring emergency obstetric care: a handbook*, Geneva, 2009.

WHO recommendations on adolescent health: guidelines approved by the WHO Guidelines Review Committee. Geneva: World Health Organization; 2017 (WHO/MCA/17.08). Licence: CC BY-NC-S

ANNEX 5: Online survey questionnaire

Introduction

Euro Health Group has been commissioned by the UNFPA to conduct a mid-term evaluation of the Maternal and Newborn Health Thematic Fund (MHTF), 2018-2022. The purpose is to assess the performance of MHTF in providing catalytic support through country-owned and driven interventions to improve maternal and newborn health and rights in 32 high-mortality countries.

The evaluation's results will support implementation of the MHTF through the end of its current phase and help inform the post-2022 programming and operating model.

An online survey is an important instrument to collect data for the evaluation and we would be very grateful if you could dedicate about 15 minutes and complete our questionnaire. Please note that the survey is not accessible in the public domain, responses cannot be traced back to the respondents and the results will be treated in a confidential manner.

The deadline for completion of the questionnaire is 25 June 2021.

Thank you in advance for your time and cooperation.

If you have any question or encounter any difficulties in accessing or completing the questionnaire, please contact Ms Vera Nedic at vnedic@ehg.dk

Note

The majority of questions use a Likert scale (strongly agree – agree - neither agree, nor disagree – disagree – strongly disagree) to assess the perceptions and opinions of the respondents with regard to the role of UNFPA in HIV prevention in their country/region.

Identification

1. Please indicate the country you work in

- | | | |
|---|--|--|
| <ul style="list-style-type: none">● Bangladesh● Benin● Burkina Faso● Burundi● Chad● Congo Brazaville● Cote d'Ivoire● DRC● Ethiopia● Ghana● Guinea Conakry | <ul style="list-style-type: none">● Guinea Bissau● Haiti● Kenya● Laos● Liberia● Madagascar● Malawi● Mauritania● Mozambique● Nepal● Niger | <ul style="list-style-type: none">● Nigeria● Rwanda● Senegal● Sierra Leone● Somalia● Sudan● Timor-Leste● Togo● Uganda● Zambia |
|---|--|--|

2. Please indicate what type of organization or professional body, research or policy institute you work for

- UNFPA
- Other United Nations organization

- Multilateral or bilateral development agency or foundation
- National health authority or other ministry or government agency
- International Non-governmental organization or its national affiliate
- National/local NGO or Community-based Organization

Other (please specify)

3. Is or was your organization an implementing partner of UNFPA? In other words, did your organization spend resources from UNFPA?

- Yes
- No

4. What are the main contributions that the UNFPA through the Maternal Health Thematic Fund (MHTF) makes to MNH/ public health results in your country? (check all that apply)

- Advocacy to raise the profile of linkages between maternal and newborn health and SRHR
- Advocacy to raise the profile of the differentiated maternal and newborn health needs of vulnerable and disadvantaged women and girls
- Coordination of partners to address national MNH efforts
- Development of evidence base (e.g SOWMy report etc.), strategies, guidance and programmatic tools that can support advocacy and strengthen MNH programme quality
- Development or delivery of fundraising efforts for MNH and/ or SRHR
- Support to strengthen professionalization and capacity of midwives through improved education, training, deployment, and strengthening of midwifery professional association and regulations
- Support to expand network of health facilities offering quality SRMNH services, including EmONC
- Support to Maternal (and Perinatal) Death Surveillance and Response (MPDSR) system to strengthen maternal and perinatal death reporting and response
- Support for national strategies to end fistula and other obstetric morbidities
- Knowledge management to advance programme approaches to support integrated and evidence- based SRMNH services
- Support for life-saving equipment and commodities, including during COVID-19
- Support to health systems to mitigate impact of COVID-19 on access to and demand for SRMNH services
- Nothing
- Don't know/Not applicable

Other (please specify)

General Opinion

5. Thinking broadly about maternal and newborn health in your country, what is the clearest contribution that UNFPA has made in your view?

UNFPA contribution to midwifery education, training and deployment

6. Please indicate extent to which you agree or disagree with the following statements

- UNFPA inputs regarding norms, standards and policies have resulted in strengthened regulatory and policy environment to govern midwifery practice and workforce capacity development.
- UNFPA support to strengthen midwifery pre-service training and education programmes is technically sound, based on global standards, and aligned to national needs.
- UNFPA support to strengthen midwifery in-service training and education programmes is technically sound, based on global standards, and aligned to national needs.
- UNFPA has strengthened the capacity of midwifery organizations to support the professionalization and capacity building of midwives
- As a result of UNFPA's efforts, midwifery is today recognized (nationally & globally) as being one of the essential pathways to address maternal and newborn health and reduce maternal and newborn deaths and disabilities.
- As a result of UNFPA technical support and inputs into midwifery, there has been a sustained increase of national investments into midwifery education and expansion of the midwifery workforce.

Please provide examples of UNFPA efforts for any of the above statements. Please also describe any gaps or missed opportunities.

Define & scale-up an Emergency Obstetric and Newborn Care referral network with integrated SRH

7. Please indicate extent to which you agree or disagree with the following statements

- UNFPA has effectively conducted advocacy and policy dialogue to advance national (or sub-national) strategies and plans in support of a well-defined and functioning national network of EmONC facilities (a network of recognised and supported referral centres open 24 hours a day that can deliver emergency obstetric and newborn care).
- UNFPA support has led to a more strategic distribution of facilities within the EmONC national network to ensure equitable access.
- UNFPA support has strengthened quality improvement processes, tools and data collection to ensure quality and accountability in EmONC services.
- UNFPA inputs (such as training, capacity building, skills development, policy strengthening etc.) have led to improved capacity of skilled birth attendants to provide EmONC services.

Please provide examples of UNFPA efforts for any of the above statements. Please also describe any gaps or missed opportunities.

UNFPA contribution to establish and scale up Maternal and Perinatal Death Surveillance and Response

8. Please indicate extent to which you agree or disagree with the following statements

- UNFPA support and investment has led to the establishment and/or scale-up of evidence-based Maternal and Perinatal Death Surveillance and Response (MPDSR) in your region or country.
- UNFPA support has increased quality and credibility of the maternal and perinatal death audit or reporting.
- UNFPA support has improved the timely notification of deaths.
- UNFPA support has improved the capacity of supervisory officers at national and sub-national levels to analyse MPDSR data.

- UNFPA support has improved the capacity of supervisory officers at national and sub-national levels to respond to gaps identified in MPDSR processes and to support improvements in service delivery.

Please provide examples of UNFPA efforts for any of the above statements. Please also describe any gaps or missed opportunities.

UNFPA efforts to support national strategies for ending fistula and other obstetric morbidities

9. Please indicate extent to which you agree or disagree with the following statements

- UNFPA has strengthened government capacity to develop, implement and monitor costed and time-bound national strategies for prevention, diagnosis, repair and recovery from fistula.
- UNFPA support has strengthened expanded access to fistula prevention, diagnosis, repair and recovery services.
- UNFPA support has strengthened the quality of social reintegration/rehabilitation programmes for obstetric fistula survivors.
- UNFPA efforts have helped to broker and facilitate effective partnerships and multi-stakeholder participation for a well-coordinated fistula response.

Please provide examples of UNFPA efforts for any of the statements above. Please also describe any gaps or missed opportunities.

Strengthened integration of MNH and SRHR

10. Please indicate extent to which you agree or disagree with the following statements

- UNFPA has effectively advocated for the integration of MNH and SRHR within national strategies
- UNFPA has effectively advocated for major national strategies including Universal Health Coverage (UHC) or the Global Financing Facility supported investment case (where applicable)
- UNFPA has contributed to the implementation of evidence-based models and programme approaches for the integrated programming of MNH and SRHR service delivery, including, but not limited to postpartum family planning, post-abortion care, safe abortion services (where legal), PMTCT, GBV and cervical cancer screening and prevention.
- UNFPA coordinates across its programme and technical focus areas (maternal and newborn health, family planning, RH commodities, adolescents and youth, gender and women’s empowerment, preparing for the demographic dividend and the achievement of human rights), to ensure synergies through effective and efficient programming and technical support to country programmes

Please provide examples for any of the statements above. Please also describe any gaps or missed opportunities.

UNFPA efforts to support equitable and accountable access to integrated MNH and SRHR info/services

11. Please indicate extent to which you agree or disagree with the following statements

- UNFPA advocates for and supports national strategies that call for “leaving no one behind” and which take account of the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged.
- UNFPA technical support to national authorities has contributed to increased expenditure on strengthening equitable access to quality MNH and SRHR services.

Please provide examples for any of the statements above

UNFPA role as broker for catalytic action for the promotion of MNH in MHTF countries

12. Please indicate extent to which you agree or disagree with the following statements

- UNFPA plays an important convening role to forge partnerships, coordinate approaches and strategies, and mobilise resources to advance MNH.
- UNFPA provides catalytic support in MNH that fosters political, programmatic and financing commitments significantly beyond its own investments.
- UNFPA fosters, identifies, and supports the implementation of innovations and best practices within and among countries.

Please provide examples of any of the statements above.

13. Please provide examples of an innovation or best practice in MNH supported by UNFPA

Adapting and responding to COVID-19

14. Please indicate extent to which you agree or disagree with the following statements

- UNFPA has pursued a flexible and adaptable approach to ensure access to a continuum of life-saving SRMNH services as part of the COVID-19 response and recovery efforts.
- UNFPA has strengthened coordination and reallocated and reprogrammed MHTF funding to help maintain the continuity of SRMNH services.

15. Please provide examples of UNFPA efforts to adapt and respond to COVID-19

16. Given its limited budget, does the MHTF concentrate on supporting the right priorities?

17. Looking forward, how can UNFPA strengthen its contribution to MNH and SRHR in your country?

| |
|--|
| |
|--|

Other

18. Please provide any other thoughts not captured above regarding the implementation of MHTF.

| |
|--|
| |
|--|

Maternal Health Thematic Fund Governance and Management

FOR UNFPA STAFF ONLY

19. To what extent do you agree that

- UNFPA effectively manages its maternal health activities to facilitate efficient utilisation of resources.
- The current organization of MHTF activities (i.e., around four technical focus areas for midwifery, EmONC, MPDSR and fistula) fosters the provision of holistic technical and financial support to UNFPA Country Offices to advance MNH programming that is responsive to country needs.
- MHTF investments and activities contribute to strengthened coordination and integration with other UNFPA thematic programmes at country level.
- UNFPA has effective management and coordination systems in place to ensure MHTF works across technical “silos” among UNFPA programmes at global and national level.

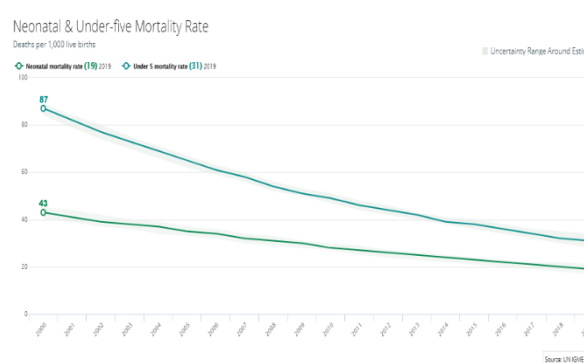
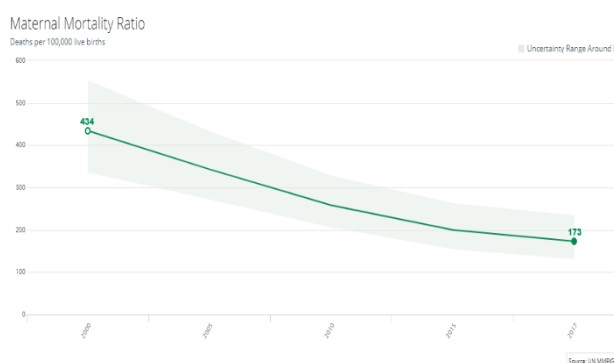
Please provide examples of UNFPA approaches to MHTF management and governance to elaborate on your responses to any of the statements above. What are your thoughts regarding alternative approaches and ways for the MHTF to deliver high quality technical support within the limitations of its funding and programmatic arrangements?

| |
|--|
| |
|--|

ANNEX 6: Country profiles

| BANGLADESH | | | | | |
|---|--------|--------|--|----------------|--------|
| General and health financing profile | | | | | |
| Indicator | Value | Source | Indicator | Value | Source |
| Total population: estimated size of population at mid-year, in millions, 2021 | 166.3 | (1) | Life expectancy at birth in years, 2021 (male/female) | 71/75 | (1) |
| GNI per capita, Atlas method (current US\$) 2019 | 1,940 | (3) | Current health expenditure as per cent of GDP, 2018 | 2% | (2) |
| Primary Health Care expenditure as per cent of current health expenditure, 2018 | N/A | (2) | Domestic general government health expenditure (% of current health expenditure/% of general government expenditure) | 16.98% / 2.98% | (3) |
| Out-of-pocket expenditure (% of current health expenditure), 2018 | 73.87% | (3) | External health expenditure (% of current health expenditure) | 6.52% | (3) |

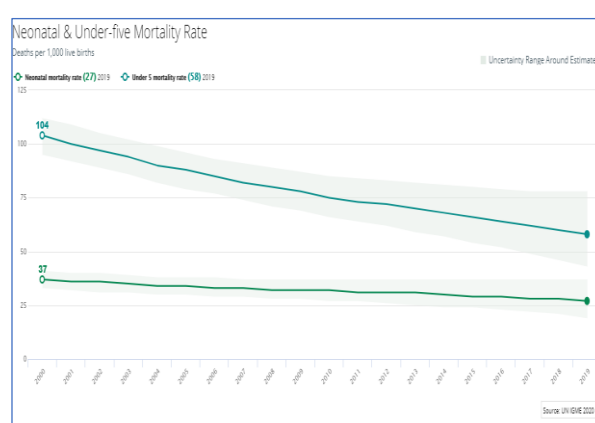
| Health and population profile | | |
|---|-----------------|--------|
| Indicator and Definition: | Indicator value | Source |
| Total fertility rate: Number of children born per woman in her lifetime. | 2 | (1) |
| Average annual rate of population change: Average exponential rate of growth over one year based on a medium variant projection | 1.1 | (1) |
| Maternal mortality ratio, 2017: Number of maternal deaths per 100,000 live births | 173 | (4) |
| Neonatal mortality rate (deaths in babies in the first month of life per 1000 live births) 2019 | 19 | (3) |
| Births attended by skilled health personnel, 2017: Percentage of births attended by skilled health personnel (doctor, nurse or midwife) | 59 | (5a) |
| Contraceptive prevalence rate, modern method (CPR): Percentage of (all) women aged 15-49 who are currently using any modern method of contraception | 55 | (1) |
| Unmet need for family planning: Percentage of (all) women aged 15-29 who want to stop or delay childbearing but are not using a method of contraception | 9 | (1) |
| Adolescent birth rate, 2020: Number of births per 1,000 adolescent girls aged 15-19 | 74 | (1) |
| Child marriage by age 18, 2019: Proportion of women aged 20-24 years who were married or in a union before age 18 | 51 | (5b) |



(1) United Nations Population Division <https://www.unfpa.org/data/world-population-dashboard> (2) World Health Organization Global Health Expenditure database <https://apps.who.int/nha/database/ViewData/Indicators/en>; (3) World Bank Data Bank: <https://databank.worldbank.org/home> accessed on 28 June 2021; (4) UN Interagency group for maternal mortality estimation <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26> (5) UNICEF (a) <https://data.unicef.org/topic/maternal-health/delivery-care/> (b) <https://data.unicef.org/resources/dataset/child-marriage/> (6) Source of graphics: <https://profiles.countdown2030.org/#/ds/UGA>

| SUDAN | | | | | |
|---|--------|--------|--|-------------|--------|
| General and Health Financing Profile | | | | | |
| Indicator | Value | Source | Indicator | Value | Source |
| Total population: estimated size of population at mid-year, in millions, 2021 | 44.9 | (1) | Life expectancy at birth in years, 2021 (male/female) | 64/68 | (1) |
| GNI per capita, Atlas method (current USD) 2019 | 820 | (3) | Current health expenditure as per cent of GDP, 2018 | 5% | (2) |
| Primary Health Care expenditure as per cent of current health expenditure, 2018 | 6% | (2) | Domestic general government health expenditure (% of current health expenditure/% of general government expenditure) | 22.8%/6.8 % | (3) |
| Out-of-pocket expenditure (% of current health expenditure) 2018 | 66.2 % | (3) | External health expenditure (% of current health expenditure) | 7.6% | (3) |

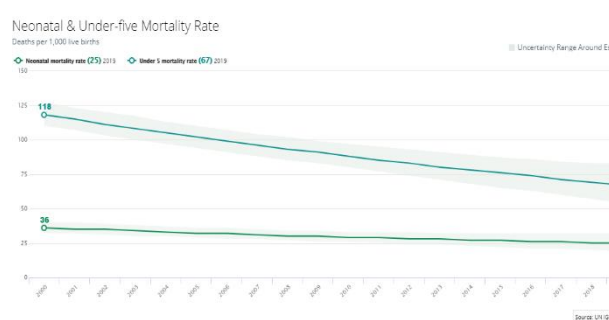
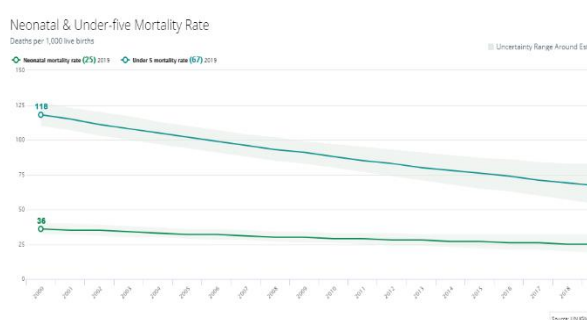
| Health and population profile | | |
|---|-----------------|--------|
| Indicator and Definition: | Indicator value | Source |
| Total fertility rate: Number of children born per woman in her lifetime. | 4.2 | (1) |
| Average annual rate of population change: Average exponential rate of growth over one year based on a medium variant projection | 2.4 | (1) |
| Maternal mortality ratio, 2017: Number of maternal deaths per 100,000 live births | 295 | (4) |
| Neonatal mortality rate (deaths in babies in the first month of life per 1000 live births) 2019 | 27.2 | (3) |
| Births attended by skilled health personnel, 2014: Percentage of births attended by skilled health personnel (doctor, nurse or midwife) | 77.7 | (5a) |
| Contraceptive prevalence rate, modern method (CPR): Percentage of (all) women aged 15-49 who are currently using any modern method of contraception | 10 | (1) |
| Unmet need for family planning: Percentage of (all) women aged 15-29 who want to stop or delay childbearing but are not using a method of contraception | 18 | (1) |
| Adolescent birth rate, 2020: Number of births per 1,000 adolescent girls aged 15-19 | 87 | (1) |
| Child marriage by age 18, 2014: Proportion of women aged 20-24 years who were married or in a union before age 18 | 34 | (5b) |



(1) United Nations Population Division <https://www.unfpa.org/data/world-population-dashboard> (2) World Health Organization Global Health Expenditure database <https://apps.who.int/nha/database/ViewData/Indicators/en>; (3) World Bank Data Bank: <https://databank.worldbank.org/home> accessed on 28 June 2021; (4) UN Interagency group for maternal mortality estimation <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26> (5) UNICEF (a) <https://data.unicef.org/topic/maternal-health/delivery-care/> (b) <https://data.unicef.org/resources/dataset/child-marriage/> (6) Source of graphics: <https://profiles.countdown2030.org/#/ds/UGA>

| TOGO | | | | | |
|---|--------|--------|--|----------------|--------|
| General and health financing profile | | | | | |
| Indicator | Value | Source | Indicator | Value | Source |
| Total Population: estimated size of population at mid-year, in millions, 2021 | 8.5 | (1) | Life expectancy at birth in years, 2021 (male/female) | 61/63 | (1) |
| GNI per capita, Atlas method (current US\$) 2019 | 690 | (3) | Current health expenditure as per cent of GDP, 2018 | 6% | (2) |
| Primary Health Care expenditure as per cent of current health expenditure, 2018 | 68% | (2) | Domestic general government health expenditure (% of current health expenditure/% of general government expenditure, 2018) | 17.04% / 2.96% | (3) |
| Out-of-pocket expenditure (% of current health expenditure) 2018 | 56.32% | (3) | External health expenditure (% of current health expenditure) | 16.80% | (3) |

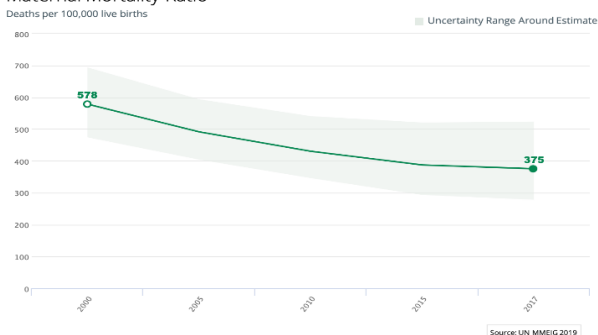
| Health and population profile | | |
|---|-----------------|--------|
| Indicator and Definition: | Indicator value | Source |
| Total fertility rate: Number of children born per woman in her lifetime. | 4.1 | (1) |
| Average annual rate of population change: Average exponential rate of growth over one year based on a medium variant projection | 2.5 | (1) |
| Maternal mortality ratio, 2017: Number of maternal deaths per 100,000 live births | 396 | (4) |
| Neonatal mortality rate (deaths in babies in the first month of life per 1000 live births) 2019 | 25 | (3) |
| Births attended by skilled health personnel, 2017: Percentage of births attended by skilled health personnel (doctor, nurse or midwife) | 69 | (5a) |
| Contraceptive prevalence rate, modern method (CPR): Percentage of (all) women aged 15-49 who are currently using any modern method of contraception | 24 | (1) |
| Unmet need for family planning: Percentage of (all) women aged 15-29 who want to stop or delay childbearing but are not using a method of contraception | 22 | (1) |
| Adolescent birth rate, 2020: Number of births per 1,000 adolescent girls aged 15-19 | 89 | (1) |
| Child marriage by age 18, 2019: Proportion of women aged 20-24 years who were married or in a union before age 18 | 25 | (5b) |



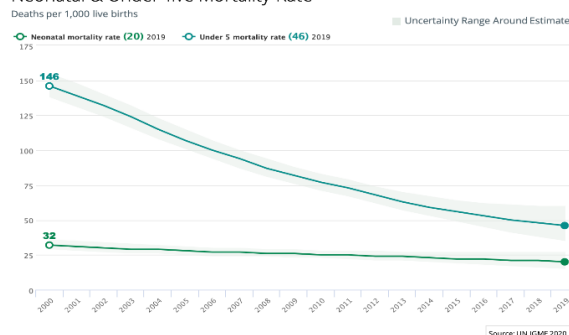
(1) United Nations Population Division <https://www.unfpa.org/data/world-population-dashboard> (2) World Health Organization Global Health Expenditure database <https://apps.who.int/nha/database/ViewData/Indicators/en>; (3) World Bank Data Bank: <https://databank.worldbank.org/home> accessed on 28 June 2021; (4) UN Interagency group for maternal mortality estimation <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26> (5) UNICEF (a) <https://data.unicef.org/topic/maternal-health/delivery-care/> (b) <https://data.unicef.org/resources/dataset/child-marriage/> (6) Source of graphics: <https://profiles.countdown2030.org/#/ds/UGA>

| UGANDA | | | | | |
|---|-------|--------|---|---|--------|
| General and Health Financing Profile | | | | | |
| Indicator | Value | Source | Indicator | Value | Source |
| Total Population: estimated size of population at mid-year, in millions, 2021 | 47.1 | (1) | Life expectancy at birth in years, 2021 (male/ female) | 62/66 | (1) |
| GNI per capita, Atlas method (current USD) 2019 | 780 | (3) | Current health expenditure as per cent of Gross Domestic Product, 2018 | 7% | (2) |
| Primary Health Care expenditure as per cent of current health expenditure, 2018 | 59% | (2) | Domestic general government health expenditure (% of current health expenditure/ % of general government expenditure) | 16%/5% | (3) |
| Out-of-pocket expenditure (% of current health expenditure) 2018 | 38% | (3) | External health expenditure (% of current health expenditure) | 43% | (3) |
| Health and population profile | | | | | |
| Indicator and Definition: | | | Indicator value | Source | |
| Total fertility rate: Number of children born per woman in her lifetime. | | | 4.6 | (1) | |
| Average annual rate of population change: Average exponential rate of growth over one year based on a medium variant projection | | | 3.6 | UNFPA calculation based on data from United Nations Population Division | |
| Maternal mortality ratio, 2017: Number of maternal deaths per 100,000 live births | | | 375 | (4) | |
| Neonatal mortality rate (deaths in babies in the first month of life per 1000 live births) 2019 | | | 17 | (3) | |
| Births attended by skilled health personnel, 2017: Percentage of births attended by skilled health personnel (doctor, nurse or midwife) | | | 74 | (5a) | |
| Contraceptive prevalence rate, modern method (CPR): Percentage of (all) women aged 15-49 who are currently using any modern method of contraception | | | 35 | (1) | |
| Unmet need for family planning: Percentage of (all) women aged 15-29 who want to stop or delay childbearing but are not using a method of contraception | | | 19 | (1) | |
| Adolescent birth rate, 2020: Number of births per 1,000 adolescent girls aged 15-19 | | | 132 | (1) | |
| Child marriage by age 18, 2019: Proportion of women aged 20-24 years who were married or in a union before age 18 | | | 34 | (5b) | |

Maternal Mortality Ratio



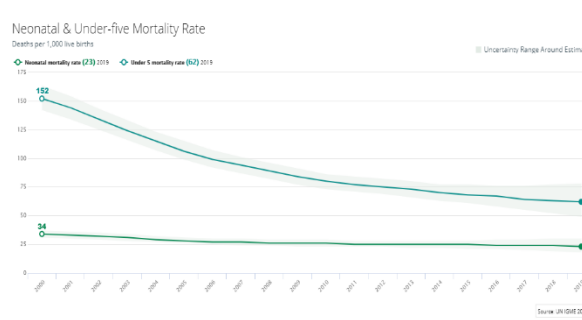
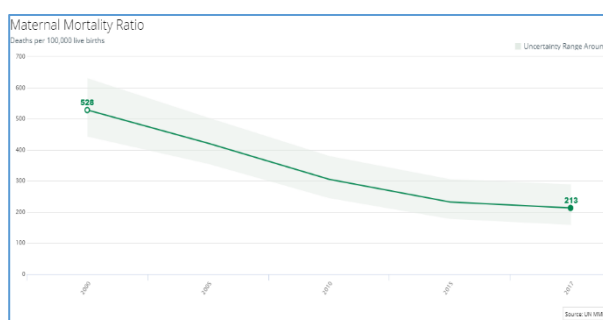
Neonatal & Under-five Mortality Rate



(1) United Nations Population Division <https://www.unfpa.org/data/world-population-dashboard> (2) World Health Organization Global Health Expenditure database <https://apps.who.int/nha/database/ViewData/Indicators/en>; (3) World Bank Data Bank: <https://databank.worldbank.org/home> accessed on 28 June 2021; (4) UN Interagency group for maternal mortality estimation <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26> (5) UNICEF (a) <https://data.unicef.org/topic/maternal-health/delivery-care/> (b) <https://data.unicef.org/resources/dataset/child-marriage/> (6) Source of graphics: <https://profiles.countdown2030.org/#/ds/UGA>

| ZAMBIA | | | | | |
|---|-------|--------|--|----------------|--------|
| General and health financing profile | | | | | |
| Indicator | Value | Source | Indicator | Value | Source |
| Total Population: estimated size of population at mid-year, in millions, 2021 | 18.9 | (1) | Life expectancy at birth in years, 2021 (male/female) | 61/68 | (1) |
| GNI per capita, Atlas method (current US\$) 2019 | 1,430 | (3) | Current health expenditure as per cent of GDP, 2018 | 5% | (2) |
| Primary Health Care expenditure as per cent of current health expenditure, 2018 | 79% | (2) | Domestic general government health expenditure (% of current health expenditure/% of general government expenditure, 2018) | 39.08% / 7.04% | (3) |
| Out-of-pocket expenditure (% of current health expenditure) 2018 | 9.98% | (3) | External health expenditure (% of current health expenditure) | 44.56% | (3) |

| Health and population profile | | |
|---|-----------------|--------|
| Indicator and Definition: | Indicator value | Source |
| Total fertility rate: Number of children born per woman in her lifetime. | 4.4 | (1) |
| Average annual rate of population change: Average exponential rate of growth over one year based on a medium variant projection (2015-2020) | 2.9 | (1) |
| Maternal mortality ratio, 2017: Number of maternal deaths per 100,000 live births | 213 | (4) |
| Neonatal mortality rate (deaths in babies in the first month of life per 1000 live births) 2019 | 23 | (3) |
| Births attended by skilled health personnel, 2015: Percentage of births attended by skilled health personnel (doctor, nurse or midwife) | 80 | (5a) |
| Contraceptive prevalence rate, modern method (CPR): Percentage of (all) women aged 15-49 who are currently using any modern method of contraception | 37 | (1) |
| Unmet need for family planning: Percentage of (all) women aged 15-29 who want to stop or delay childbearing but are not using a method of contraception | 15 | (1) |
| Adolescent birth rate, 2020: Number of births per 1,000 adolescent girls aged 15-19 | 135 | (1) |
| Child marriage by age 18, 2019: Proportion of women aged 20-24 years who were married or in a union before age 18 | 29 | (5b) |



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