

THE MATERNAL HEALTH THEMATIC FUND

Towards the 2030 Agenda:
Leaving no one behind in the
drive for maternal health

Annual Report 2015





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

Cover photo:

© Evelyn Matsamura Kiapi, UNFPA.

Winner MHTF Annual Report 2015 photo competition

OVERJOYED: Twenty-year-old Betty Nachu was one of the expectant mothers found waiting to deliver her baby at Rengen Health Centre II in Uganda's Kotido district. She had travelled from Nakwakwa, a 10-kilometre journey, to wait for her labour to start. She was expecting her second child any time and chose to deliver at the health centre on the advice of a midwife. Only 19 per cent of women in Karamoja, a north-eastern region of Uganda, deliver at a health centre. Traditionally, the majority of pregnant women deliver at home; Nachu was not an exception at her first delivery. When two UNFPA-supported bonded midwives visited her village during a community outreach session, they convinced Nachu that giving birth at a health centre was safer. The bonded midwives sensitize expectant mothers about the benefits of delivering at the health centre under skilled care.

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ACKNOWLEDGEMENTS

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We acknowledge, with gratitude, the support of donor countries in strengthening sexual and reproductive health and rights. In particular, we would like to thank the governments of Germany, Iceland, Luxembourg and Sweden.

Our nurturing partnership with the private sector and civil society also needs special mention. We thank Friends of UNFPA, Johnson & Johnson, the Laerdal Foundation and the UNFCU Foundation for their generous support. A special note of thanks goes to many individual donors, UN trust funds and foundations.

Our sincere thanks to our UN colleagues around the globe at the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), UN Women, the World Bank Group and the World Health Organization (WHO), which in collaborating with UNFPA are making a stronger partnership as H4+ and now H6.

Our results in this report, across our headquarters, regional and country offices, reflect UNFPA's vision and mission for maternal health as an integral part of sexual and reproductive health. Significant contributions come from our programme partners, which include the International Confederation of Midwives, the International Federation of Gynecology and Obstetrics, the Maternal and Child Survival Program of the United States Agency for International Development (USAID), AMREF Health Africa, the International Society of Obstetric Fistula Surgeons, Columbia University's Averting Maternal Death and Disability Program, Johns Hopkins University, Jhpiego, the Alan Guttmacher Institute, the University of Aberdeen, the Wilson Centre, Women Deliver, EngenderHealth, Family Care International, Integrare, and national and regional partners listed in Annex 1 for the Campaign to End Fistula. We value their significant roles as champions and technical experts in sexual and reproductive health and rights.

UNFPA looks forward to continued productive collaborations and valued partnerships in achieving the Sustainable Development Goals (SDGs).

ACRONYMS

ANC	Antenatal Care
EmONC	Emergency Obstetric Newborn Care
FGM/C.....	Female Genital Mutilation/cutting
GIS	Geographic Information System
GNI.....	Gross National Income
FTYM.....	First-Time Young Mothers
H6 (<i>formerly H4+</i>)	UNAIDS, UNFPA, UNICEF, UN Women, World Bank Group and WHO
HRH	Human Resources for Health
ICM.....	International Confederation of Midwives
Jhpiego.....	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MDG.....	Millennium Development Goal
MDSR	Maternal Death Surveillance and Response
MHTF.....	Maternal Health Thematic Fund
MMR.....	Maternal Mortality Ratio
NGO	Non-Governmental Organization
PPP.....	Purchasing Power Parity
RMNCAH.....	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goal
SIDA.....	Swedish International Development and Cooperation Agency
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA.....	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID.....	United States Agency for International Development
WHO	World Health Organization



FOREWORD

*By Dr. Babatunde Osotimehin
Executive Director, UNFPA*

In 2015, the global community embraced a far-reaching and ambitious sustainable development agenda. This historic, universal and inclusive agenda provides a vision and springboard with the commitment to leave no one behind and reach the furthest behind first.

UNFPA is at the forefront in supporting countries to translate the vision and goals of the 2030 Agenda for Sustainable Development into tangible deliverables that can make a sizeable difference in people's lives, particularly women and girls. We are committed to accelerating global efforts to end preventable maternal deaths and ensure access to quality sexual and reproductive health services by 2030 with the goal of improving the health and quality of life of women and girls, especially those most marginalized, disadvantaged and underserved.

Our flagship Maternal Health Thematic Fund (MHTF) is on the frontline in contributing to this goal – a unique programme in the UN system that utilizes an innovative and integrated results-based approach to improve maternal health with key interventions in 39 countries with some of the highest maternal mortality and morbidity in the world.

The MHTF works with and complements our UNFPA supplies programme, which aims to strengthen access to a wide range of quality and reliable contraceptive and maternal health supplies. Together these two UNFPA flagship programmes are increasing women's and girls' access to comprehensive quality sexual and reproductive health services when and where they need them.

The MHTF facilitates a targeted and effective response to maternal mortality and morbidity across several dimensions. This includes strengthening health systems; ensuring the availability of quality emergency obstetric and newborn health services; improving access to skilled birth attendance with a strong emphasis on midwifery; and reaching first-time young mothers with an approach tailored to their specific needs.

The MHTF mobilizes to support countries to effectively address childbirth complications; strengthen accountability at all levels of the health system by both registering and addressing the causes of maternal deaths of women and girls; and increase the availability of quality surgery and rehabilitation for survivors who live with obstetric fistula.

This annual report highlights the critical contribution of the MHTF programme to improving maternal health in 2015, with results that include support to 265 midwifery schools with the potential to train more than 12,800 midwives; the facilitation of 13,000 surgical fistula repairs; support to the training of more than 900 fistula survivors in income-generating activities; and more broadly strengthening health systems to deliver quality maternal health services through targeted interventions addressing emergency obstetric and newborn care, and maternal death surveillance and response. Collectively in the 39 countries supported by the MHTF, maternal deaths have fallen from 223,274 in 2010 to 205,214 in 2015.

Such results would not be possible without the support and dedication of all our partners at all levels – national governments, civil society organizations, UN agencies, and development and private sector partners. This includes the essential role our country partners have played at the national and sub-national level in working to make a positive difference in the lives of women and girls, alongside our key regional and global partners, which include the UN Secretary-General’s Every Woman, Every Child initiative, the Campaign on Accelerated Reduction of Maternal Mortality in Africa, the H6 partnership (UNAIDS, UNICEF, UN Women, World Bank Group, WHO and UNFPA), Columbia University’s Averting Maternal Death and Disability programme and others.

Let me also extend my sincere thanks and appreciation to our donors – Germany, Iceland, Luxembourg, Friends of UNFPA, Johnson and Johnson, and Sweden, the main donor of the MHTF.

Every preventable maternal death is unacceptable and deeply heart-breaking. Notwithstanding the significant strides that the world has made to reduce the annual number of maternal deaths from approximately 532,000 in 1990 to 303,000 in 2015, we need to do more and better by accelerating and increasing investments in such proven and effective solutions as demonstrated by the MHTF – interventions grounded in human rights and upholding the principles of gender equality and equity.

At UNFPA we are committed to the achievement of universal access to sexual and reproductive health and the protection of reproductive rights so that every pregnancy is wanted, every childbirth is safe and every young person’s potential is fulfilled. We believe that such investments are not only right, they are essential if we as a global community are to realize our commitments to the 2030 Agenda for Sustainable Development and deliver for women and girls.

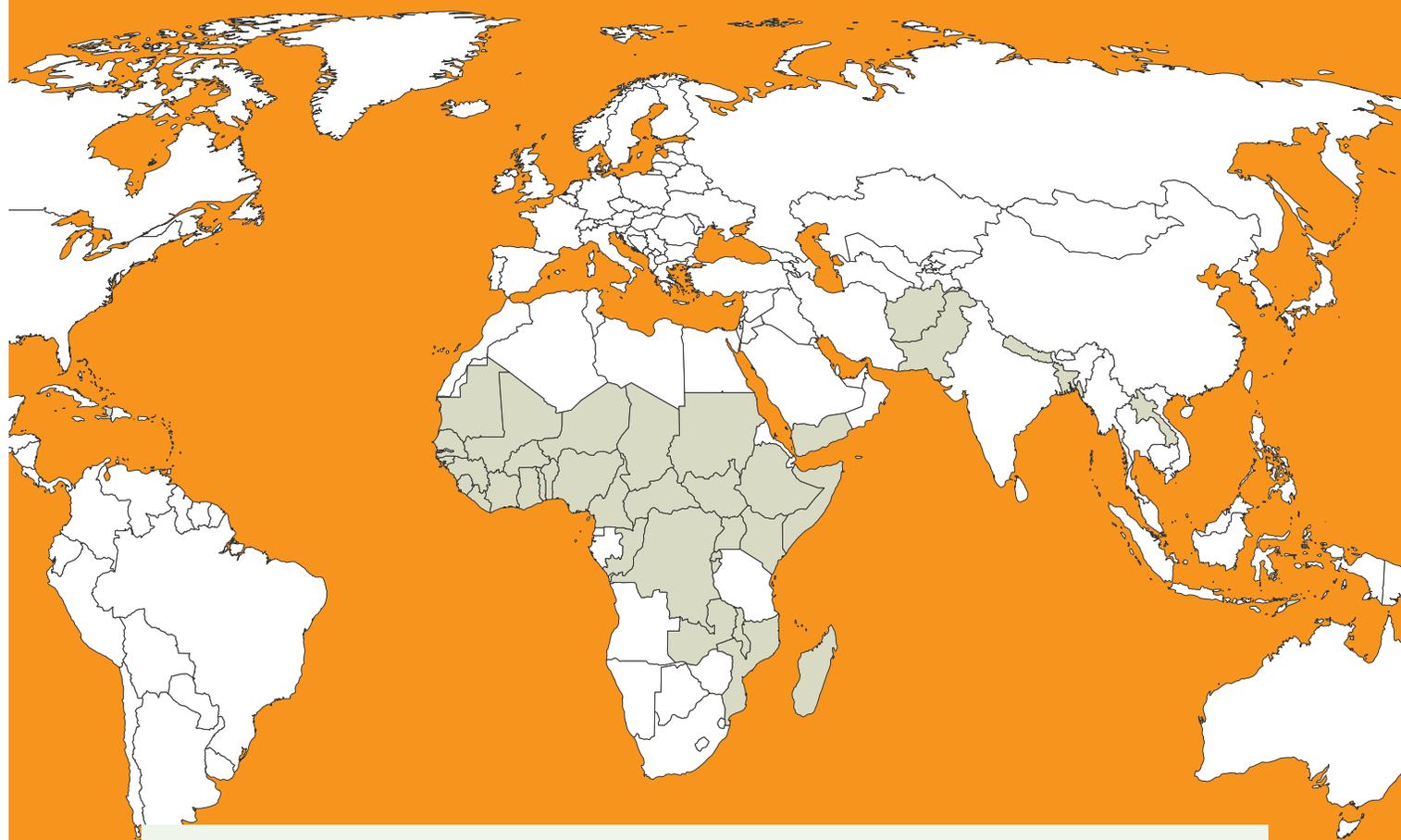
A handwritten signature in white ink on an orange background. The signature is cursive and appears to read "Peter Steiner".

39 MHTF-SUPPORTED COUNTRIES

Afghanistan
Bangladesh
Benin
Burkina Faso
Burundi
Cameroon
Central African Republic
Chad
Congo
Côte d'Ivoire
Democratic Republic
of the Congo
Ethiopia
Ghana

Guinea
Guinea-Bissau
Haiti
Kenya
Lao People's
Democratic Republic
Liberia
Madagascar
Malawi
Mali
Mauritania
Mozambique
Nepal
Niger

Nigeria
Pakistan
Rwanda
Senegal
Sierra Leone
Somalia
South Sudan
Sudan
Timor-Leste
Togo
Uganda
Yemen
Zambia



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

INTRODUCTION

The Maternal Health Thematic Fund (MHTF) is UNFPA's flagship programme for improving maternal and newborn health and well-being. It is the only programme of its kind in the UN system that focuses on strategic interventions to strengthen health systems and improve equitable access to quality maternal and newborn health services, which are key sexual and reproductive health services.

The MHTF supports 39 countries with a high burden of maternal mortality in five priority areas: to increase the availability and quality of their midwifery workforce; to ensure equitable access to quality emergency obstetric and newborn care services in case pregnant women experience complications; to set up a national maternal death surveillance and response system to register and review the case of every woman who dies in pregnancy and childbirth in order to prevent future deaths; to strengthen the prevention and treatment of obstetric fistula and support the social reintegration of women and girls with fistula, including those deemed incurable or inoperable; and to address the needs of first-time young mothers, often still children themselves, who are particularly vulnerable during pregnancy, childbirth and caring for their newborns.

The second year of implementation of the MHTF Business Plan (2014-2017) has been transformative for global development. 2015 was marked by escalating efforts at all levels to advance the realization of the Millennium Development Goals (MDGs). This was reflected by a strong push to address those MDGs where progress lagged behind, such as MDG 5 on improving maternal health, which was the goal that was furthest off-track. At the same time, the global community worked together to agree on a successor to the MDGs, the 2030 Agenda for Sustainable Development, with its 17 Sustainable Development Goals (SDGs). The SDGs build on the achievements of the MDGs and aim to complete their unfinished agenda. They are far-reaching in vision and scope, with a universal approach of leaving no one behind.

The SDGs will be addressed in more detail in the first chapter of this 2015 report, which highlights progress achieved by the MHTF. Individual chapters on the five MHTF components follow and provide key highlights and results under each area, while reflecting the numerous links among all five. The financial overview chapter details income and expenditures. The final chapters focus on opportunities and the way forward, discussing the importance of the MHTF in scaling up progress in maternal and newborn health and well-being.

Overall, this 2015 MHTF report demonstrates the importance of the Thematic Fund in contributing to the reduction of maternal and newborn mortality and morbidity, and the protection, promotion and fulfilment of the rights of women and girls. As a catalytic fund, it supports high-burden countries to implement evidence-based, high-impact interventions that strengthen health systems and close gaps in the availability and quality of maternal and newborn health services. The MHTF contributes to building foundations for reaching the new SDG targets on reducing maternal mortality, for ending the preventable deaths of newborns and children under five, and for ensuring universal access to sexual and reproductive health care.

Maternal Health Thematic Fund Components:

- Midwifery;
- Emergency Obstetric and Newborn Care;
- Maternal Death Surveillance and Response;
- Obstetric Fistula;
- First-Time Young Mothers.



After losing her house in Nepal's 2015 earthquake, 16-year-old Shreejana BK, who lives in the rural Rasuwa district, found a reason to smile again the day she safely delivered her first child at a UNFPA-supported reproductive health camp.
©Santosh Chhetri, UNFPA. Photo submitted for MHTF Annual Report 2015 photo contest.

1 | OVERVIEW

HIGHLIGHTS

In 2015, 38 countries received MHTF funding **for maternal health and/or fistula activities**.

The MHTF in 2015 continued to provide a clear vision to support the implementation of effective interventions that contribute to ending preventable maternal and newborn deaths; and improve the health and well-being of women and girls.

Since 2010 **the maternal mortality ratio has declined by 14 per cent in the 39 countries supported by the MHTF**, corresponding to a reduction in the annual number of maternal deaths from 223,274 in 2010 to 205,214 in 2015.

Through the MHTF supported Midwifery Programme, UNFPA helped support 8,339 midwives to undergo pre-service training and assisted 265 midwifery schools in 2015 alone.

To strengthen the national monitoring of Emergency Obstetric and Newborn Care in MHTF-supported countries, 2015 saw a strong focus on strengthening the quality of data collected and use.

In 2015, the MHTF instigated the utilization of the maternal death notification rate and the proportion of maternal and newborn deaths reviewed to measure both the implementation and performance of Maternal Death Surveillance and Response Systems in MHTF-supported countries.

Over 13,000 fistula repair surgeries were supported by UNFPA through the MHTF in 2015.

In 2015, **the MHTF supported the procurement of 568 fistula repair kits** for use at health facilities in 17 MHTF-supported countries.

Nine more MHTF-supported countries prioritized first-time young mothers in national reproductive, maternal, newborn, child and adolescent health plans in 2015.

In 2015, **UNFPA created a Non-Core Fund Management Unit** to coordinate non-core financial resources of thematic funds, including the MHTF. This helps to strengthen harmonization, integration and increase synergies across thematic areas.

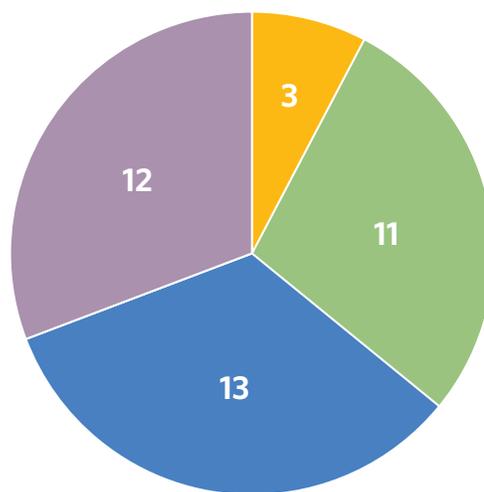
2015 was a pivotal year for global development. The 15-year implementation period of the MDGs came to an end, and the world agreed on an ambitious new development framework applicable to all countries – Transforming Our World: The 2030 Agenda for Sustainable Development. This builds on the achievements of the MDGs and addresses what remains to be finished, including MDG 5 on improving maternal health. The Agenda has also been underpinned by an overall financing framework, the Addis Ababa Action Agenda, agreed at the Third High-Level Conference on Financing for Development in mid-2015. It outlines the global community’s strong political commitment to financing the 2030 Agenda.

As part of supporting the operationalization of the 2030 Agenda, the UN Secretary-General launched a new Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030) that not only addresses survival but also aims at ensuring that all women, children and adolescents exercise their rights to thrive, and can be part of transforming their societies and communities. The strategy takes a life-course perspective that aims for the highest attainable standards of health and well-being – physical, mental and social – at every age. It adopts an integrated and multi-sector approach, recognizing that health-enhancing factors, including nutrition, education, water, clean air, sanitation, hygiene and infrastructure, are essential to achieving the SDGs. Through the Every Woman Every Child, a global multi-stakeholder movement supporting the vision and goals of the strategy, more than 100 organizations and over 50 countries pledged their commitment to improving women’s, children’s and adolescents’ health and well-being, with a total of over US \$25 billion in commitments.

The MDGs – Spanning 15 Years of Global Development

The MDGs showed the power that shared goals and targets have in mobilizing the world around a clearly defined development agenda. The health MDGs (including MDG 5) successfully raised the profile of global health to the highest political level, mobilized civil society, supported the generation of domestic and external resources, and stimulated investments in neglected areas such as sexual and reproductive health and rights. 2015 estimates show that globally the maternal mortality ratio fell by nearly 44 per cent between 1990 and 2015. As shown in Figure 1.1, 14 countries supported by the MHTF have done better than this average. Three countries (Lao People’s Democratic Republic, Rwanda and Timor-Leste) achieved the MDG 5 target of a 75 per cent reduction of their maternal mortality ratios, and another six countries (Afghanistan, Bangladesh, Ethiopia, Mozambique, Nepal and Zambia) achieved very significant progress with a 60-plus per cent reduction.

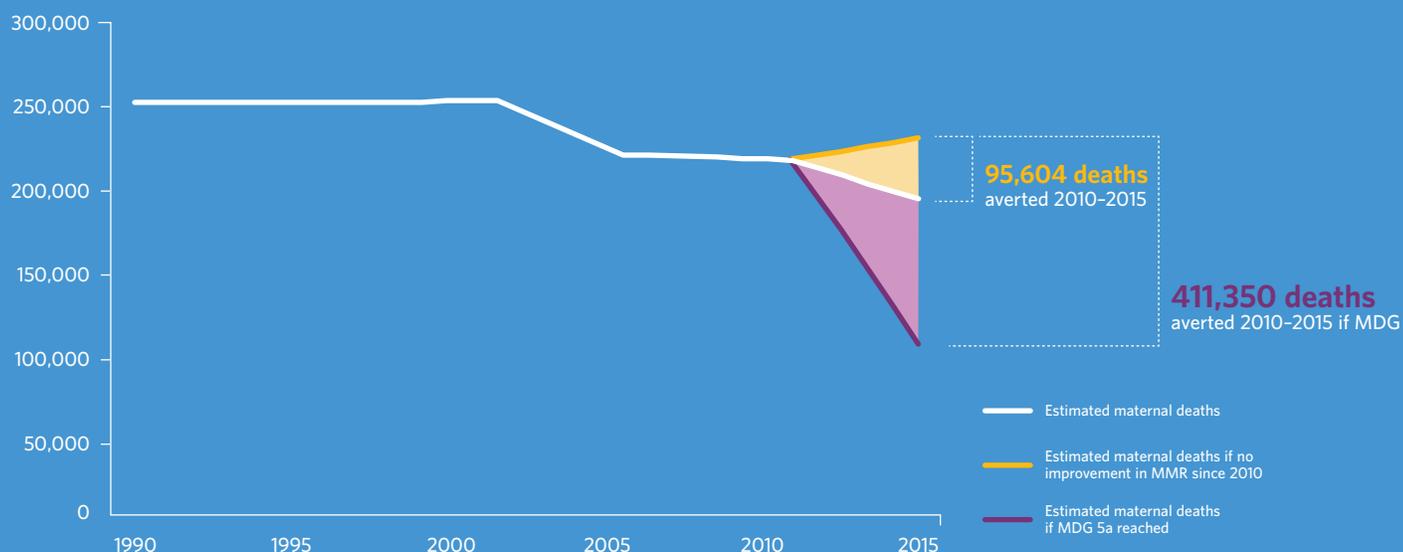
Figure 1.1: Progress of MHTF-supported countries in achieving the MDG 5 target on reducing maternal mortality



- Achieved: Maternal mortality rate reduction point-estimate of $\geq 75\%$
- Making progress. Reduction point-estimate of $\geq 50\%$ and $\geq 90\%$ probability of a reduction of $\geq 25\%$
- Insufficient progress: Reduction point-estimate of $\geq 25\%$ and $\geq 90\%$ probability of a reduction of $\geq 0\%$
- No progress: reduction point-estimate of $< 25\%$ or 90% probability that there has been no reduction or there has been an increase

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

Figure 1.2: Estimated maternal deaths in the 39 MHTF-supported countries, 1990-2015



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

Since the launch of the Global Strategy for Women’s and Children’s Health in 2010, the maternal mortality ratio has declined by 14 per cent in the 39 countries supported by the MHTF, corresponding to the reduction of the annual number of maternal deaths from 223,274 in 2010 to 205,214 in 2015. As shown in Figure 1.2, an estimated 96,000 maternal deaths have been averted in the 39 MHTF-supported countries since 2010, compared to the estimated number without a reduction in the maternal mortality ratio over the same period.¹

Notwithstanding such successes, MDG 5 and its two targets – 5A, on reducing by three-quarters the maternal mortality ratio, and 5B, on achieving universal access to reproductive health care – continued to lag far behind all other MDG targets. Neither was realized by the end of 2015. The estimated 96,000 averted maternal deaths only correspond to 23 per cent of the 411,350 deaths that would have been averted since 2010 if the MDG targets for maternal health had been reached in the 39 MHTF-supported countries.²

In response, the Ending Preventable Maternal Mortality initiative in 2015 issued strategies to end preventable maternal mortality that focus on equitable access to and quality of sexual, reproductive, maternal and newborn health-care services. These strategies emphasize the critical

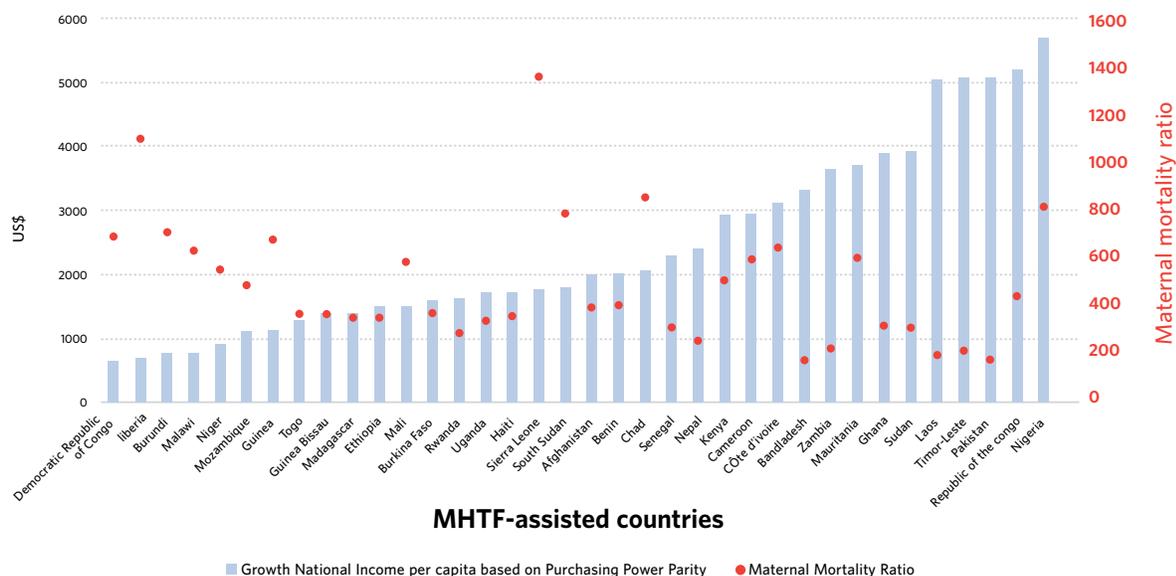
role of health providers, particularly midwives, in reducing maternal mortality, and the importance of countries investing in emergency obstetric and newborn care. Both the initiative and the Independent Expert Review Group of the UN Secretary-General’s Global Strategy for Women’s and Children’s Health also highlight how countries must improve metrics, measurement systems and data quality to ensure accountability for improved quality of care and equity in access.

Finally, further political commitment and good governance are required across the 39 MHTF-supported countries to ensure that every woman accesses quality health services. As highlighted by Figure 1.3, an increase in domestic resources does not necessarily lead to a reduction in maternal mortality. Nigeria has a higher maternal mortality ratio than the Democratic Republic of the Congo, for instance, even though Nigeria’s gross national income (GNI)³ is more than 10 times higher. The Republic of Congo has almost the same maternal mortality ratio as Mozambique, while its GNI is about five times higher. Further, a low GNI does not prevent countries from effectively reducing maternal mortality.

¹ See Annex 2 on maternal death averted.
² Ibid

³ GNI per capita based on purchasing power parity (PPP). PPP GNI is gross national income converted to international dollars using purchasing power parity rates. An international dollar has the same purchasing power over GNI as a U.S. dollar has in the United States. GNI is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad. Data are in current international dollars based on the 2011 ICP round (source: World Bank Group)

Figure 1.3: Maternal mortality ratio and GNI per capita based on purchasing power parity (US\$) in MHTF-supported countries



Source: Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization, 2015, and World Bank Group Databank, accessed in May 2016 [HERE](#).

Operationalizing the SDGs

The transformational 2030 Agenda encompasses 17 SDGs and 169 targets that balance the three dimensions of sustainable development – environment, economic and social. At the same time, all goals and targets are interlinked and integrated.

New targets on maternal mortality, newborn deaths and universal access to sexual and reproductive health are found under SDG 3, on ensuring healthy lives and promoting well-being for all at all ages, and SDG 5, on achieving gender equality and empowering all women and girls.

The targets are as follows:

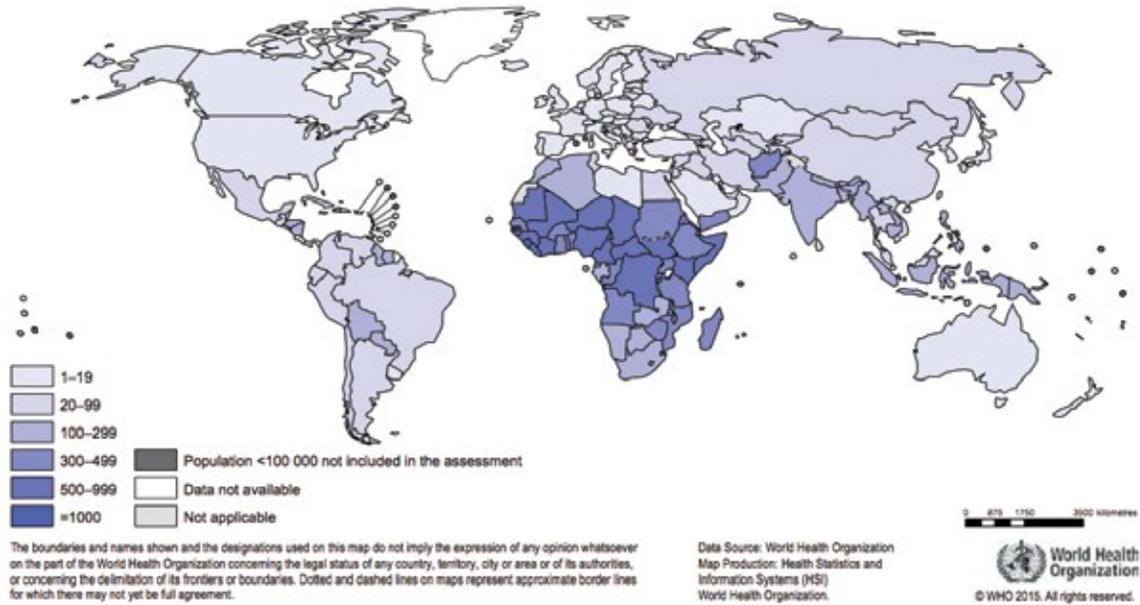
- 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

- 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

Among MHTF-supported countries, the estimated maternal mortality ratios in 2015 ranged from 176 to 1,360 maternal deaths per 100,000 live births. To reach target 3.1, 34 of these countries need to reduce maternal mortality ratios by 75 per cent to 95 per cent before 2030. The remaining five countries need to reduce it by 60 per cent to 75 per cent.

Progress for the MDGs was measured for a 25-year period, with 1990 as the baseline and 2015 as the end date. With only 15 years available to reach the new SDG targets, most MHTF-supported countries will need to significantly scale up actions within a much shorter timeframe in order to reach SDG 3.

Map 1.1: Maternal mortality ratios in 2015



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

Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)

The MHTF’s support to countries is reinforced by its global and regional partnerships. Through its collaboration with the H6 (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank Group), civil society and the private sector, the MHTF contributes to the operationalization of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030), under the umbrella of the UN Secretary-General’s Every Woman, Every Child. The Global Strategy, launched in September 2015, envisages a world in which every woman, child and adolescent in every setting realizes her or his right to physical and mental health and well-being, enjoys social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies. Its three main objectives are to enable individuals to:

- **Survive:** by ending preventable deaths;
- **Thrive:** by ensuring health and well-being, including ensuring universal access to sexual and reproductive health-care services and rights; and

- **Transform:** by expanding enabling environments for health and well-being, including eliminating all harmful practices, and all discrimination and violence against women and girls, and ensuring that all girls and boys complete free, equitable and good-quality primary and secondary education.

In May 2016, the 69th World Health Assembly voted a resolution inviting countries “to commit, in accordance with their national plans and priorities, to implementing the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030).”⁴

⁴ Source: World Health Assembly 69.2, Agenda item 13.3, Committing to implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health.



UNFPA supplied equipment to Timor-Leste's national hospital in capital, Dili, which aids in reducing maternal mortality and improving child delivery.
© Martine Perret, United Nations.

The MHTF Vision

Within the overarching frameworks of the SDGs and the Global Strategy, the MHTF offers a clear vision of how to reduce maternal mortality and morbidity, and contribute to the health and well-being of women and girls.

Women and girls should be empowered to demand, access and utilize quality maternal health services.

Every birth should be attended by a skilled birth attendant, and to this end, midwifery should be a recognized and regulated profession with adequate educational opportunities, career advancement and professional associations.

Skilled birth attendants should work in functional teams at health-care facilities that have sufficient human resources and supplies to continuously offer quality maternal and newborn health services, including emergency obstetric and newborn care, and other sexual and reproductive health services, such as for family planning and sexually transmitted infections.

Facilities should be geographically distributed with a minimum of five facilities providing emergency obstetric

and newborn care services for each 500,000 inhabitants, of which at least one should be a comprehensive facility. Functional referral and transportation systems should be in place to enable timely referral from basic to comprehensive emergency obstetric and newborn care facilities in case of complications.

All complications, responses and outcomes – including maternal and newborn deaths as well as stillbirths – should be registered, and a maternal death surveillance and response system should be in place to identify, understand and act on prevalent causes of maternal deaths in order to prevent them.

Special measures should be taken to meet the needs of particularly vulnerable groups of first-time young mothers and women living with obstetric fistula.

In other words, there is no shortcut to achieving and sustaining results: maternal and newborn mortality and morbidity need to be prevented and managed within a functioning, supplied and well-staffed health system with close links with communities, and regular reporting, monitoring and management systems for continued improvement.

The MHTF Business Plan

The MHTF Phase II Business Plan identifies six outcome areas for the MHTF to achieve its vision. The Business Plan is fully aligned with the UNFPA Strategic Plan 2014-2017, with the overarching goal being implementation of Outcome 1, Output 3 of the Integrated Results Framework of the Strategic Plan: “increased national capacity to deliver comprehensive maternal health services.”

The six outcomes areas of the MHTF Business Plan are:

1. Strengthened national capacity to implement comprehensive midwifery programs;
2. Strengthened national capacity for emergency obstetric and newborn care, including quality integrated maternal health services;
3. Enhanced national capacity for prevention, treatment and social reintegration for women and girls with obstetric fistula;
4. Enhanced national capacity for maternal death surveillance and response;
5. Enhanced attention to pregnant adolescents and adolescent mothers; and
6. Strengthened coordination and management of the MHTF.

Comparative Strengths of the MHTF

As a global programme, the MHTF has comparative strengths in:

- **State-of-the-art technical expertise:** MHTF-supported countries receive advice from global and regional experts on maternal and newborn health, and more broadly sexual and reproductive health. The MHTF also helps globally develop the field of maternal and newborn health at the technical level, for instance, through various Lancet series and guidance notes created with the WHO and other partners.

- **Global advocacy:** The MHTF calls attention to issues related to maternal and newborn health, including through celebration of the International Day to End Obstetric Fistula, the International Day of the Midwife, and dialogues and debates, as in a series done in collaboration with the Wilson Centre.
- **Support to regional initiatives:** These include the Campaign on Accelerated Reduction of Maternal Mortality in Africa, launched by 44 countries in 2009. In 2015, the MHTF supported campaign-related advocacy for maternal and newborn health in Chad and Somalia.
- **South-South cooperation:** The MHTF helps identify, share and facilitate the exchange of best practices, lessons learned and innovative solutions among countries. With its technical expertise, it facilitates adaptation of best practices to national contexts.
- **Programme collaboration:** As a global programme with a national presence, the MHTF is well positioned for strategic partnerships not only with other global actors, but also with other programmes with a multi-country presence. In 2015, the MHTF Midwifery Programme entered into a partnership with the UNFPA-coordinated “UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM/C)” in order to strengthen the involvement of midwives in FGM/C abandonment efforts over 17 African countries.
- **Data:** Improving maternal health through evidence-based policies and national programming requires quality data collection and analysis. The MHTF helps to generate, share and enable the use of relevant data. For example, in 2015, it supported the launch of a regional version of the State of the World’s Midwifery Report 2014, which analysed the availability, accessibility, acceptability and quality of sexual, reproductive, maternal and newborn health services in 13 Arab states. The MHTF has also supported emergency obstetric and newborn care needs assessments in three countries, and the set-up and strengthening of the monitoring of emergency obstetric and newborn care facilities in two countries.

Management and Monitoring Tools

The Results Indicators Framework

A Results Indicators Framework was developed for the MHTF Phase II in 2014 – see Annex 3. It measures progress towards Business Plan outcomes and assists countries in generating data for strengthening programme management and monitoring. For example, it allows the tracking of:

- The number of midwifery schools supported by the MHTF that follow International Confederation of Midwives/WHO standards,
- National monitoring of emergency obstetric and newborn care facilities,
- The strengthening of national capacities to treat obstetric fistula, and
- The level of focus and coverage of services for first-time young mothers.

The framework allows expenditure data to be disaggregated according to the MHTF Business Plan outcome areas and not only by key intervention areas. As such, it permits a more detailed analysis of MHTF interventions and resource allocations.

Other Management Tools

In addition to the Results Indicators Framework, which captures results at the country, global and regional level; country annual workplans, midyear and annual reports serve as important management and monitoring tools for the MHTF.

In 2015, UNFPA further integrated the planning and management of its thematic funds. Countries submitted an integrated annual workplan for the MHTF; the UNFPA supplies programme; the Unified Budget, Results and Accountability Framework (UNAIDS); and the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM/C). In addition, UNFPA created a Non-core Funds Management Unit to coordinate non-core financial resources of thematic funds (including the MHTF). It helps to foster harmonization, integration and transparency, and increase synergies with programmes supported by UNFPA's regular (or core) resources.

Key Intervention Areas of the MHTF in Supporting the Strengthening of Health Systems

The MHTF has five key intervention areas: midwifery, emergency obstetric and newborn care, maternal death surveillance and response, the Campaign to End Fistula and first-time young mothers. Each of the five areas is discussed in individual chapters of this report, although they should be considered comprehensively. All five are interrelated and contribute to improving the functioning of health systems, specifically the access of women and girls to quality maternal health services, including other sexual and reproductive health services.

Midwifery

Quality midwifery care is central to ensuring the health and well-being of women and newborns. Midwives constitute the key workforce to provide sexual and reproductive health services to women and girls, from the pre-pregnancy and antenatal periods to postnatal follow-up, family planning, and testing for and care of sexually transmitted infections, including HIV. Midwives who are fully qualified to international standards and are working within a functioning health system can provide 87 per cent of the essential care needed for women and newborns.⁵

MHTF support to midwifery is aligned with the UNFPA Midwifery Programme operating in more than 70 countries. It aims to build national capacities for **strengthening midwifery education and training**, including through the implementation of International Confederation of Midwives/WHO standards for pre-service training. It also helps **enhance midwifery regulatory mechanisms**, and **establish and strengthen midwifery associations**.

In addition, the MHTF supports global, regional and national advocacy for midwives. In collaboration with the International Confederation of Midwives, WHO, World Bank and UNFPA regional offices, the MHTF helps develop national capacities to use the latest data from the *State of the World's Midwifery Report 2014* in bolstering midwifery workforce policies. In 2015, technicians in over 30 countries learned to conduct more in-depth national workforce assessments based on the data by applying the Sexual, Reproductive, Maternal, Newborn and Adolescent Health Workforce Assessment Tool launched in 2015.

⁵ Source: *State of the World's Midwifery Report 2014*.

Number of midwifery schools following the International Confederation of Midwives standards in MHTF-supported countries.

+31%
between 2013-2015

UNFPA through the MHTF also supports the celebration of the International Day of the Midwife, which spotlights the importance of their roles.

The MHTF has backed high-level advocacy on midwifery at major global events, such as the Global Maternal and Newborn Health

Conference in Mexico, and the International Federation of Gynecology and Obstetrics World Congress in Vancouver. It assists the Midwives4All social media platform, an initiative of the Swedish Ministry of Foreign Affairs that aims to spark greater discussion on the benefits of investing in midwifery and evidence-based practices.

In 2015, innovative multimedia e-learning modules on lifesaving skills and family planning were widely disseminated in 25 countries and converted to allow midwives to use them on mobile phones and tablets.

Chapter Two provides more on the Midwifery Programme.

Emergency Obstetric and Newborn Care

As pregnant women and their newborns are at highest risk of death and morbidity during labour, childbirth and the first week after birth, investing in improved access to and quality of care, especially emergency obstetric and newborn care, is essential. Despite a global increase in coverage of skilled birth attendance, associated declines in maternal mortality and morbidity have been modest, and for stillbirths virtually non-existent. With haemorrhage, hypertensive disorders and sepsis responsible for more than half of maternal deaths worldwide, it is critical for countries to strategically develop and monitor a national network of maternity services offering basic and comprehensive emergency obstetric and newborn care services, and linked with other facilities, to ensure women and girls reach quality services on time.

The MHTF supports countries to develop, strengthen and monitor their network of emergency obstetric and newborn care facilities. It specifically helps in conducting

needs assessment surveys, developing costed workplans, and monitoring facilities based on regular collection and analysis of data, followed by actions addressing any gaps.

Globally, as part of the Ending Preventable Maternal Mortality Working Group, the MHTF in 2015 contributed to a core set of maternal health indicators for global monitoring and reporting by all countries, which are included in the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health Indicator Framework.

Chapter Three covers emergency obstetric and newborn care activities in more detail.

Maternal Death Surveillance and Response

In health-care facilities, maternal death surveillance and response systems promote continuous monitoring to identify trends in and causes of maternal mortality, and to prevent future deaths.

The MHTF supports countries to set up and strengthen their maternal death surveillance and response framework, including a costed plan for development, a formal notification process for maternal deaths in facilities, and a national maternal death surveillance and response committee. It assists as well with reporting and monitoring of performance of maternal death surveillance and response.

Since 2014, in addition to monitoring policies and frameworks, the MHTF has tracked the maternal death notification rate in all 39 of the countries it assists. Surveys in 2014 and 2015 showed that while most countries have a partial or full policy framework, maternal death notification rates remain low. Data collected enables the MHTF to provide targeted technical assistance to countries and facilitate exchanges of experiences among them.

Globally, the MHTF advocates for moving beyond policy frameworks and further focusing on the results of maternal death surveillance and response systems in terms of maternal death notification and reviews by improving the availability and quality of data, and strengthening analysis and the implementation of appropriate responses.

More on maternal death surveillance and response systems appears in Chapter Four.



Luciana, 48, discussing obstetric fistula repair from experience, with women in her community in Namathanda District, Mozambique.
 © Helene Christensen, UNFPA.

Obstetric Fistula

Without adequate access to skilled attendance at birth and to necessary services – notably C-sections – women are at risk of developing obstetric fistula through prolonged obstructed labour. This condition leaves them incontinent and often excluded from their communities. Obstetric fistula is preventable and, in most cases, treatable through surgery. But sufficient services are not available, and women may not know of existing services or be able to access them.

Identification of women with obstetric fistula for referral to services is one intervention that the MHTF supports. Recent examples include training health workers in Ethiopia, devising a good practices document on fistula case identification and referral in Ghana, and conducting awareness-raising with local partners in the Democratic Republic of the Congo. The MHTF also helps countries to increase the number of qualified surgeons who can perform fistula repairs, and works with partner organizations at global, regional and national levels to promote high-quality surgical training, including through South-South collaboration.

Direct support also goes towards thousands of surgical fistula repairs. More than half of all fistula repairs globally are supported by UNFPA, totaling 13,000 repairs in 2015

in 36 countries, the majority of which received MHTF funding. This represented an increase in the annual number UNFPA could support. Repairs are facilitated through fistula repair kits that UNFPA developed, containing necessary medical instruments and supplies for fistula repairs and post-operative care.

Finally, the MHTF assists countries in adopting adequate policies, strategic plans and institutional set-ups – for instance, task forces – to end fistula. Advocacy and awareness-raising mobilize governments, leaders and the public to prioritize obstetric fistula in health interventions. Global and national advocacy takes place in connection with the International Day to End Obstetric Fistula, observed on May 23rd, since 2013.

The MHTF is a key contributor of the Campaign to End Fistula, a global initiative led and coordinated by UNFPA. It aims to make obstetric fistula as rare in developing countries as it is in the industrialized world.

Chapter Five highlights more on obstetric fistula.

First-Time Young Mothers

Young adolescent mothers are less likely to seek necessary prenatal care and more at risk for adverse outcomes of pregnancy and childbirth, leading to high rates of death and illness. For example, an estimated 65 per cent of women with obstetric fistula develop this condition during their adolescence.⁶ With targeted interventions, the risks associated with pregnancy and childbirth should decrease, and first-time young mothers could return to school and make empowered life choices.

The MHTF works with countries to increase the number of first-time young mothers delivering with a skilled birth attendant, to boost uptake of postpartum family planning to prevent or space pregnancies, and to improve decision-making power related to sexual and reproductive health and rights. Key interventions include quality sexual and reproductive health services; group support with pregnancy, and parenting counseling for women and couples; and policy advocacy at the national level to include first-time young mothers in the national sexual and reproductive health plan.

In its first full year of implementation, the programme has sought to identify innovative and scalable interventions for first-time young mothers in 10 countries. In Liberia, in the midst of the national Ebola crisis, an innovative project reached out to these mothers to avert maternal deaths, and ensure pre- and postnatal care.

Through data monitoring, evaluation and adjustments of interventions supported in these 10 countries, the MHTF plans to expand the approach to nine other countries and to further integrate this component in its other four areas of work.

For more on first-time young mothers, see Chapter Six.

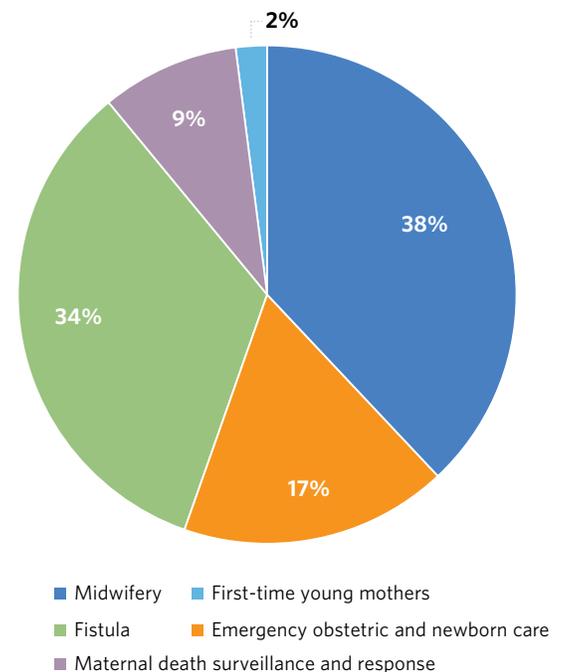
Resources and Management

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

In 2015, the operating budget for maternal health was US \$18.5 million, and almost a third (38 per cent or US \$3.4

million) of all MHTF expenditures in countries* went to the midwifery component (see Figure 1.4). It was closely followed by the Campaign to End Fistula (34 per cent or US \$3 million) and emergency obstetric and newborn care activities (17 per cent or US \$1.5 million). Interventions related to maternal death surveillance and response systems (9 per cent or US \$800,000) and first-time young mothers (2 per cent or US \$200,000) remain relatively small in scope.

Figure 1.4: The 2015 breakdown of MHTF expenditures by focus area



* The breakdown includes country activities and staff expenditures related to MHTF intervention areas as defined in the MHTF results framework (representing US \$9 million). It does not include: (a) approved activities that cover multiple maternal health/sexual and reproductive health areas, such as technical support in the development of reproductive, maternal, newborn and child health national plans, (b) approved activities that are relevant for MHTF intervention areas but not directly linked to the generic results framework, and (c) coordination/management/monitoring and reporting costs. Does not include data for Central African Republic, Guinea Bissau and Mali.

The financial implementation rate – expenditures compared to allocations – for the MHTF as a whole reached 87 per cent in 2015.

More on MHTF resources and management appears in Chapter Seven.

⁶ Source: www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/, accessed on 24 June 2016.



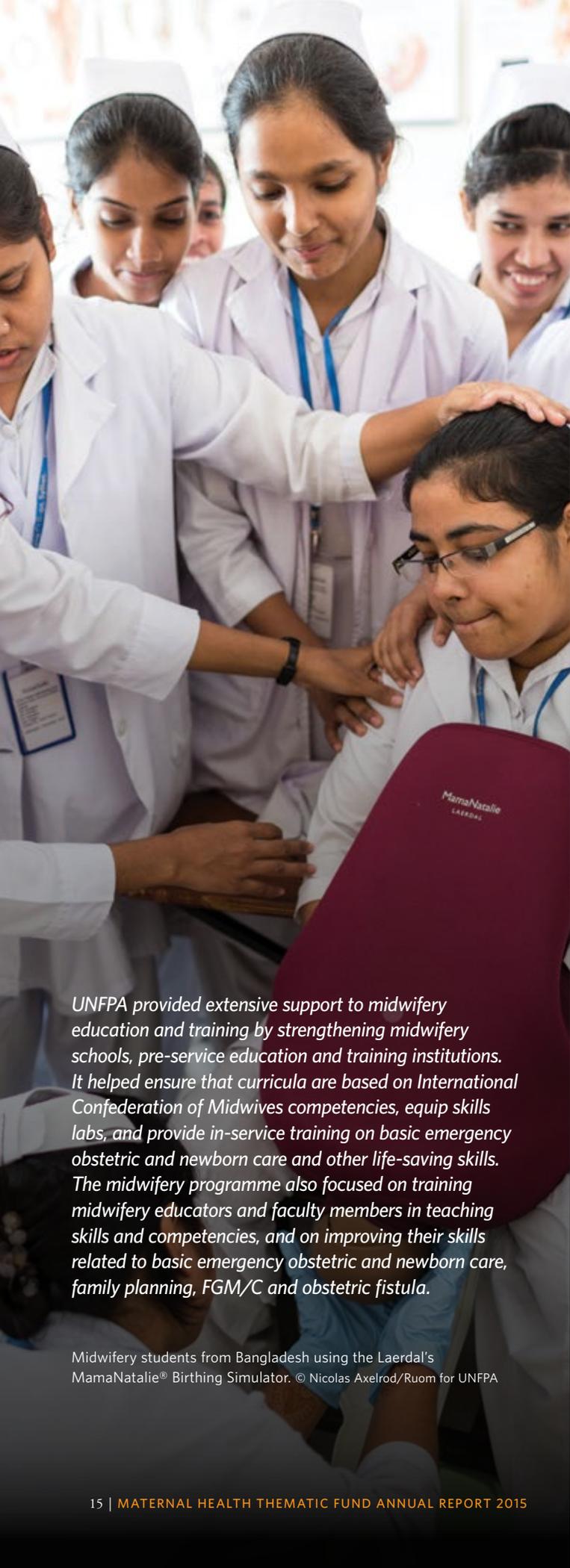
In Rwanda in 2015, a midwife cares for a newborn in Mahama Refugee Camp.
©Maureen Twahirwa, UNFPA. Photo submitted by Mathias Gakwerere for MHTF Annual Report 2015 photo contest.

2 | THE MIDWIFERY PROGRAMME

HIGHLIGHTS

The midwifery component of the MHTF supports countries to develop and implement comprehensive policies for midwifery education and regulation, based on global standards from the International Confederation of Midwives/WHO. The MHTF also supports the establishment and strengthening of **midwifery associations** as well as **advocacy for investments in quality midwifery services**. Key results in MHTF-supported countries in 2015 included:

- **All 38 MHTF-supported countries are now implementing the International Confederation of Midwives/WHO standards for midwifery pre-service training, 31 per cent more than in 2013 (Nepal was excluded as there was no midwifery school there).** Since 2009, 29 MHTF-supported countries have revised their pre-service training curriculum for midwifery to follow the standards; **16 countries reported that all their midwifery schools are now compliant with ICM standards.**
- **Over 265 midwifery schools and training institutions were strengthened with equipment and training materials,** with the potential for training more than 12,800 midwives annually.
- **Over 832 midwifery tutors upgraded their skills to provide competency-based education and training.**
- **More than 8,339 midwives were supported with pre-service education,** with the potential for annually assisting around 1.5 million births. **Across 24 MHTF-supported countries, the public health sector hired about 12,000 midwives.** Since 2009, the MHTF has helped countries train over **58,000 midwives (both pre- and in-service).**
- **All 39 MHTF-supported countries had a midwifery national association.** In 2015, the MHTF helped 13 national associations to develop and implement a costed plan, resulting in **25 national associations with such a plan (64 per cent of MHTF-supported countries).**
- **Seven additional countries developed and implemented a national costed midwifery workforce plan** as part of a national human resources for health plan. In total, 24 countries (59 per cent of MHTF-supported countries) had a national costed midwifery workforce plan.
- Seven new countries established a **governing body to regulate midwifery practice, increasing the total number of countries with a regulatory midwifery body to 27 (69 per cent of MHTF-assisted countries).**
- Over **30 countries** strengthened capacities **to use data from the State of the World's Midwifery Report 2014** and conduct in-depth national **workforce assessments** using the Sexual, Reproductive, Maternal, Newborn and Adolescent Health Workforce Assessment Tool launched in 2015.
- Kenya developed a national **strategic plan** and launched its **first national midwifery association.**
- The **Arab States region** published a **regional midwifery report with national midwifery profiles of 13 countries** not included in the *State of the World's Midwifery Report 2014*.
- **A global initiative on FGM/C and midwifery** began engaging midwives in the elimination of this harmful practice. This initiative targets **17 African countries** under the **joint UNFPA-UNICEF FGM/C programme.**

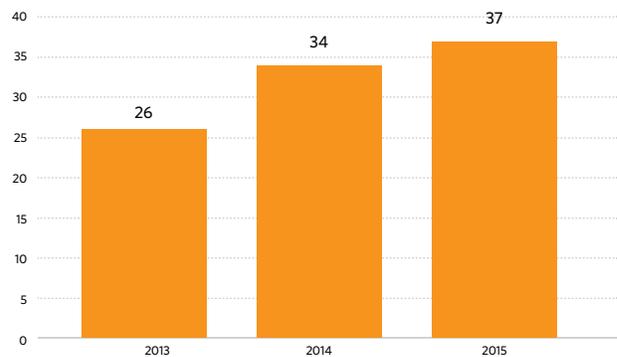


Country Highlights

Midwifery Education

Between 2013 and 2015, midwifery schools in **11 MHTF-supported countries** adopted International Confederation of Midwives standards (Figure 2.1). Some countries are still in the development stages, such as Uganda, although a related policy will likely soon be implemented.

Figure 2.1: Number of countries following the International Confederation of Midwives education standards



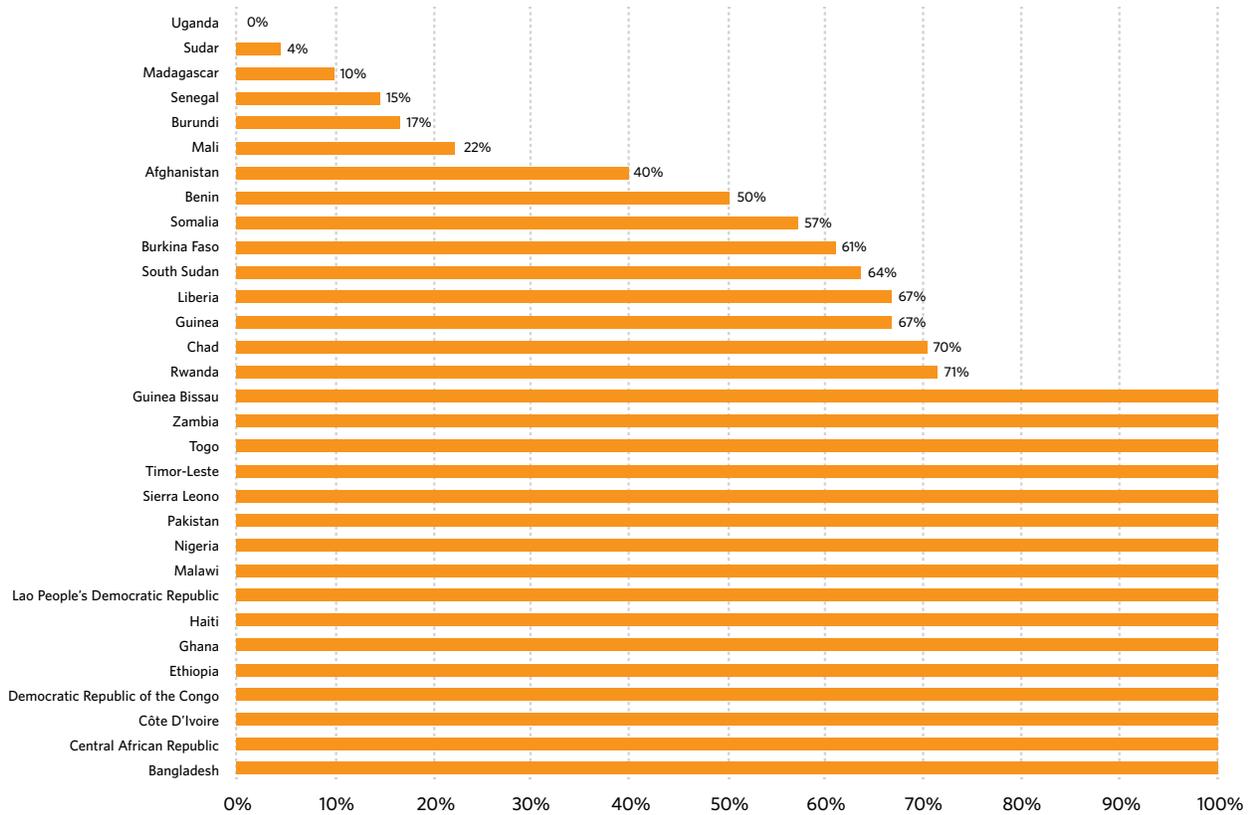
In 2015, UNFPA assisted **8,339 midwifery students** in 35 MHTF-supported countries, helped **265 schools** acquire new equipment (books, skills labs) and aided in training **832 teachers or faculty**. Tutors learned mentorship, teaching and clinical skills to deliver better evidence-based education to midwifery students in **Madagascar, Malawi, Mali, Pakistan** and **Uganda**. They updated their knowledge in family planning in **Burundi** and **Nigeria**, and were trained to use e-learning modules in **Cameroon** and **Rwanda**. In **Ghana, Côte d'Ivoire** and **Nigeria**, more than 100 tutors updated their skills in post-partum haemorrhage and neonatal resuscitation management by using the Laerdal Helping Mothers Survive/Helping Babies Breathe initiative. In **Côte d'Ivoire**, 45 master trainers in turn helped improve the skills and capacities of 625 midwives.

Among 35 MHTF-supported countries, 69 per cent of schools had a curriculum following International Confederation of Midwives standards in 2015; 16 countries had 100 per cent (Figure 2.2).

UNFPA provided extensive support to midwifery education and training by strengthening midwifery schools, pre-service education and training institutions. It helped ensure that curricula are based on International Confederation of Midwives competencies, equip skills labs, and provide in-service training on basic emergency obstetric and newborn care and other life-saving skills. The midwifery programme also focused on training midwifery educators and faculty members in teaching skills and competencies, and on improving their skills related to basic emergency obstetric and newborn care, family planning, FGM/C and obstetric fistula.

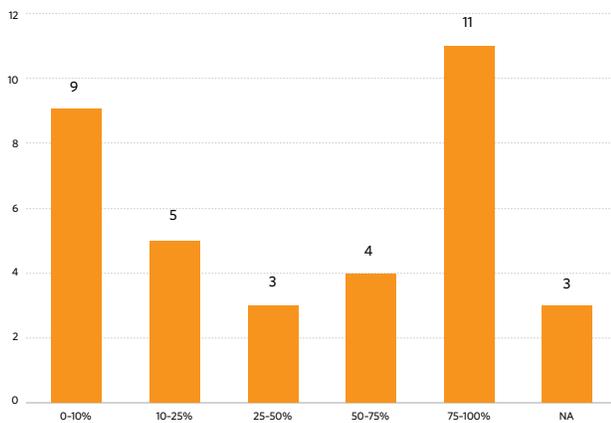
Midwifery students from Bangladesh using the Laerdal's MamaNatalie® Birthing Simulator. © Nicolas Axelrod/Ruom for UNFPA

Figure 2.2: Percentage of schools following the International Confederation of Midwives standards



In Côte d'Ivoire, Haiti, Lao People's Democratic Republic, Mauritania, Republic of Congo, Rwanda, Sierra Leone, Somalia, Timor-Leste and Togo, the MHTF supported 100 per cent of schools (Figure 2.3).

Figure 2.3: Percentage of schools supported by the MHTF in different countries in 2015



Forty-five per cent of 35 MHTF-supported countries do not have an accredited emergency obstetric and newborn care centre for training midwifery students. In 2015, Afghanistan had only one accredited centre for 20 midwifery schools. These centres are critical for getting well-qualified midwives into clinical settings.

Funding from the MHTF for midwifery since 2009 has allowed Lao People's Democratic Republic to achieve its goal of training 1,500 community midwives. In 2015, with UNFPA support, a three-year direct entry midwifery curriculum was approved by the Ministry of Education. The new programme replaces the previous two-year curriculum and is based on International Confederation of Midwives competencies. Further, the Midwifery Improvement Plan 2016-2020, aligned with the new Reproductive, Maternal, Newborn and Child Health Strategy and all other relevant strategies, has been completed and endorsed by the Ministry of Health. The plan reflects strong government commitment to maternal and newborn health by aiming for universal access to midwifery care.

Leveraging the impact of the MHTF – A case study from Ethiopia

The Ethiopian Federal Ministry of Health in the past few years has shifted its focus from training many midwives (a flooding strategy) to improving the quality of midwifery education and services with support from UNFPA and other partners. Some key results include:

- The Ministry of Health developed a supportive supervision system for graduates with Midwifery Standards of Practice. The midwifery curriculum has been harmonized with International Confederation of Midwives standards and is used by 100 per cent of schools.
- In 2011, the Ministry of Health implemented the Accelerated Midwifery Programme, training graduated nurses to become professional midwives, with support from the MHTF and the Swedish International Development Cooperation Agency (SIDA). Ethiopia achieved its target of training 8,635 midwives as its pledge under Every Woman Every Child, ahead of the 2014 deadline.
- Between 2011 and 2015, UNFPA helped train 4,471 midwives in 15 health sciences colleges in six regions. It also provided support to 33 midwifery training institutions with skills lab equipment, books and vital teaching materials, and helped establish a new midwifery school in the Gode region bordering Somalia. In 2015, training took place for 254 midwives, mostly from health centres, on the Helping Babies Breathe/Helping Mothers Survive initiative and on FGM/C. It was organized in collaboration with the Ethiopia Midwifery Association and covered all 11 regions. The White Ribbons Alliance training manuals were adapted, and UNFPA helped develop the Participants Manual and Facilitators Guide to train about 154 midwives in respectful maternity care. In addition, 193 clinical preceptors learned to instruct students in clinical areas.
- UNFPA has steadily helped build the capacity of the Midwifery Association by providing office equipment, and training on advocacy and communications. It has supported two new branches of the association in the Tigray and Amhara regions, and the development of the association's strategic plan and its evaluation. Other assistance goes towards activities to mark the International Day of the Midwife every year.
- Funding from the H6 has backed the development of the Participants Manual and Facilitators Guide for Coaching and Mentorship to be used throughout Ethiopia; completion of a study on the acceptability of male midwives and development of a Midwifery Roadmap 2015-2025.

To address the critical shortage of midwives (only 193 in the public workforce), UNFPA in **Liberia** completed a two-week orientation for 33 retired and newly graduated midwives, who were then deployed to the sub-national level. Pre-service educational standards for midwifery were also developed and disseminated. In 2015, Liberia celebrated the graduation of the first batch of 27 midwives supported by the MHTF to earn bachelors of science midwifery degrees.

With technical support from UNFPA and the International Confederation of Midwives, a systematic gap analysis of the midwifery programme in **Kenya** was conducted and an action plan drawn up, in collaboration with the Ministry of Health and all relevant midwifery stakeholders. UNFPA also supported the training of 40 midwifery managers on leadership, management and governance in collaboration

with AMREF Health Africa. Thirty-nine midwives in **Madagascar** and 20 midwives in **Ghana** also received training in management and leadership.

A mid-term review of **Zambia's** 2011-2015 National Health Strategic plan noted severe challenges in human resources for health, impeding equitable access to health service delivery. Specifically, an analysis of the availability of midwives found that less than 50 per cent of established posts have been filled. There are currently only 10.99 core health workers for reproductive, maternal, newborn and child health services per 10,000 people, which falls short of the WHO recommended threshold of 23 per 10,000. The MHTF helped support 87 midwives in pre-service training, and align the midwifery curriculum to International Confederation of Midwives standards at 100 per cent of schools in 2015.

The maternal mortality ratio of Somalia is particularly high: 732 per 100,000 live births. In 2015, 37 new midwives trained with UNFPA support graduated with high marks from an 18-month program at the Mogadishu Midwifery School. Maymuun Abdullahi Nur, 22 years old, returned home to Lower Shabelle and has been a practicing midwife there for five months. "I am glad that my dream has now come true, and I am now helping women give birth safely," she said.

Maymuun's mother died while giving birth, and ever since, she was determined to become a midwife. "I decided there and then that I would train to help save the lives of women in rural areas," she explained.

Source: www.unfpa.org/news/midwives-frontlines-fighting-maternal-death-somalia

Midwifery Regulations

The MHTF continued to support national midwifery and nursing councils in developing regulatory standards, accreditation mechanisms, midwifery scope of practice guidelines and codes of ethics.

Seven new countries have a governing body regulating midwifery practice since 2015: **Bangladesh, Burundi, Chad, Ethiopia, Mauritania, Nepal** and **Senegal**. This means 70 per cent of MHTF-supported countries now have such a body.

In **Côte d'Ivoire**, in preparation for the election of members of the National Council of the College of Midwives and Skilled Births, sensitization missions in five regions encouraged the involvement and commitment of midwives. Roughly **500 midwives** and policy makers were familiarised with the national midwifery code of ethics. Four sub-national midwifery associations were formed in four health districts.

The Nursing and Midwifery Council (formerly the Nursing Council) of **Kenya** approved direct entry midwifery training in colleges. UNFPA also supported the first National Midwifery Strategic Plan to guide the midwifery programme, highlighting strategies to address gaps in education, regulation and association.

In **Madagascar**, the National Midwives Council produced an updated midwifery data registry, and 24 members of national and regional councils were trained in leadership, advocacy and technical communication.

The **Pakistan Nursing Council**, with MHTF support, has developed midwifery workforce policies based on International Confederation of Midwives and WHO standards, with a draft policy disseminated at a national level in 2015. UNFPA also supported the Council in developing a two-year, competency-based curriculum in line with ICM midwifery education guidelines.

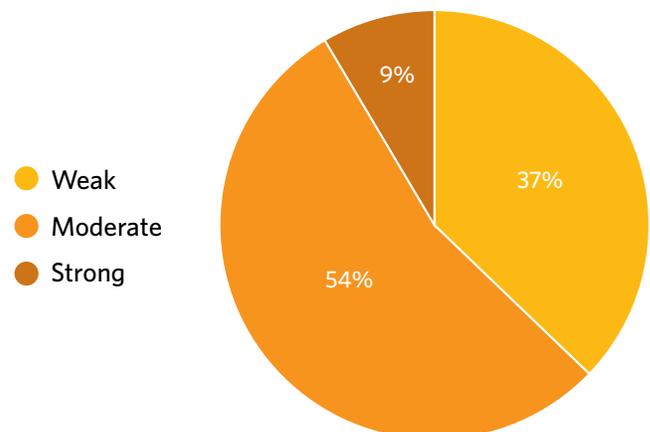
In **Uganda**, UNFPA supported the Nurses and Midwives Council to decentralize registration centres to 13 regional referral hospitals. This has helped increase the number of midwives who renew their licenses, and reduce time spent on traveling to the national centre in Kampala.

Midwifery Associations

UNFPA continued to help build the capacities of national and sub-national midwifery associations in all MHTF-assisted countries and beyond. It supported associations in increasing their membership; assessing and addressing capacity gaps; building leadership and advocacy skills; and drafting and evaluating their strategic action plans.

According to an MHTF survey of 35 countries in 2015, all have an association of midwives. Their capacities to influence policy vary, however (Figure 2.4). Only three countries (9 per cent) reported a strong midwifery association in terms of influencing policy and decision-makers: **Haiti, Madagascar** and **Pakistan**. In 2015, the association in **Madagascar** supported learning on respectful care during maternity for all pre- and in-service training participants.

Figure 2.4: Capacities of midwifery associations to influence policy in 35 MHTF-supported countries in 2015





Midwife doing consultations at Savannakhet hospital (Lao PDR).
© Micka PERIER, UNFPA

A number of Ministries of Health - **Burkina Faso**, **Ethiopia**, **Nigeria** and **Senegal** collaborated with midwifery associations and other professional medical bodies to increase the engagement of health providers in preventing FGM/C, ending the medicalization of this harmful practice, and providing more girls and women with quality care. The Ministry of Health in Puntland (**Somalia**) is finalizing an assessment of a constitution of the health associations that would help end the medicalization of FGM/C in both private and public health facilities.

In 2015, 25 (64 per cent) of MHTF-supported countries reported that their national midwifery association had a budgeted strategic action plan, 13 more than in 2014. The Midwives Association of **Benin** adopted a budgeted strategic plan for 2016-2020. A new strategic plan for the **Ethiopia** Midwifery Association was drafted, reviewed and validated in collaboration with experts from training institutions, the Ministry of Health and midwifery practitioners. In **Burundi**, UNFPA hired a consultant to help develop a strategic plan for the Midwifery Association. The Midwives Association of **Togo** validated its strategic plan.

Liberia's Midwifery Association completed the revision of its constitution. Statutes and regulations for convening the General Assembly of the National Association of Midwives in **Guinea Bissau** were finalized, and it will convene in 2016 to elect officers and approve a workplan. In **Ghana**, UNFPA has been working with the Ministry of Health to enhance effective collaboration between the Ghana

Registered Midwives Association and the Government Registered Midwives Group. **Kenya** formed a Midwifery Association by consensus and nominated interim officials. The capacity of the newly formed Kenyan Midwives Association and the **Madagascar** Midwives Association and three sub-national midwifery associations were assessed using the Midwives Association Capacity Building Tool of the International Confederation of Midwives. The **Rwanda** Association of Midwives similarly conducted a capacity gap assessment. Several countries in Africa (e.g., **Chad**, **Niger** and **Togo**) supported the participation of national association members in the First Congress of the Midwives Associations Federation of Francophone Africa, held in Bamako, Mali from 27 to 29 October 2015.

UNFPA continued to build the capacity of the Midwifery Society of **Nepal**. In 2015, activities were re-programmed and nurse midwives mobilized to provide support for the earthquake response. Five reproductive health mobile camps were conducted in Nuwakot district in coordination with the District Health Office and the Midwifery Society, and 1,474 affected people were provided with services such as safe delivery, antenatal care, postnatal care, family planning, basic emergency obstetric and newborn care, rape treatment and psychosocial support.

The constitution of the **Lao People's Democratic Republic** Association of Midwives was signed by the Minister of Health, which now allows the professional association to operate legally.

UNFPA, with SIDA support, organized a national midwifery symposium in **Uganda** attended by over 200 midwives and policy makers from around the country, including His Excellency the Ambassador of Sweden in Uganda. An idea to establish a national midwifery association was mooted and a task force established.

UNFPA supported provision of an United Nations Volunteer midwife to the Midwives Association of **Zambia** to help build leadership and advocacy capacity. This led to a six-months partnership with the Swedish Embassy to implement the Midwives4All national campaign in the North Western Province; it raises awareness on the role of midwives in reducing maternal mortality and promoting adolescent health.

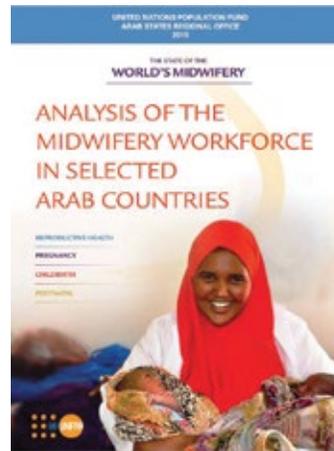
Regional Highlights

Regional activities reinforced national and global efforts to scale up the quality and harmonization of competency-based midwifery education; strengthen regulations; build policy commitments and investments; and ensure equitable deployment, distribution and retention of midwives. These efforts included developing midwifery country profiles; building capacities for workforce assessments; analysing midwifery priorities and developing strategic action plans; strengthening competency-based training programmes and enhancing midwifery leadership.

Over 100 participants from the **Asia-Pacific** region met in Bangkok from 2 to 4 March 2015 to discuss midwifery workforce issues using evidence-based midwifery tools. The workshop was carried out under the High Burden Country Initiative, created by the H6 to support countries with a high burden of maternal and newborn mortality in strengthening related policies and their implementation.

With support from UNFPA, the **Midwives Alliance for Asia** was launched at the International Confederation of Midwives regional midwifery conference in Yokohama in July. The alliance promotes collaboration among midwifery associations, and helps harmonize midwifery education and regulations per confederation standards.

The **UNFPA Regional Office in Latin America** continued to support 19 countries in strengthening competency-based midwifery. Activities included technical assistance to the regulation and education committees of the Caribbean Regional Midwives Association and the Federation of Latin American Midwives. As a result, both now have sufficient institutional capacity to conduct competency-based pre-service midwifery education programmes.



Arab States Launch Regional Midwifery Report

In November 2015, the UNFPA Arab States Regional Office released *Analysis of the Midwifery Workforce in Selected Arab Countries*. It follows the same methodology as the *State of the World's Midwifery Report 2014*,

featuring midwifery profiles from 13 Arab States. It assesses the capacity of the midwifery workforce to meet the need for sexual and reproductive health as well as maternal and newborn health services, by considering availability, accessibility, acceptability and quality.

Findings vary by country, but the report calls on governments to invest in midwifery education, training and regulation, and provides practical recommendations. It proposes various scenarios to stimulate and inform policy discussions on how the composition, skill mix and deployment of the midwifery workforce as well as an enabling environment for midwifery can improve delivery of critical sexual and reproductive health services.

Helping Mothers Survive/Helping Babies Breathe Regional Training in Senegal

A six-day training of master trainers and champions on the Helping Mothers Survive/Helping Babies Breathe initiative was co-organized in collaboration with the French Red Cross, UNFPA, the Johns Hopkins Program for International Education in Gynecology and Obstetrics (Jhpiego), AMREF Health Africa and Laerdal Global Health. The session targeted Francophone countries, notably, Burkina Faso, Chad, Guinea, Haiti, Mali, Mauritania, Niger and Senegal.

Global Highlights

Global Midwifery Survey Conducted by UNFPA

The MHTF supported a global survey gauging the impacts of UNFPA's midwifery work and tracking progress on the UNFPA Strategic Plan (2014-2017) indicator on midwifery. The survey found that:

1. UNFPA helped support some **58,000 pre- and in-service trainings** of midwives through the MHTF programme between 2009 and 2014. In 2015, **8,339 midwives underwent** pre-training (Figure 2.5). Some countries had already achieved their objectives for training midwives and required no further assistance. It is difficult to track where all graduated midwives work, but at least **12,103 midwives were recruited and placed by ministries of health in 2015**.
2. Between 2009 and 2014, UNFPA supported 429 midwifery schools through the MHTF. Assistance covered the training of midwifery tutors, reviews of curricula, and the provision of training materials and books. Among 35 MHTF-assisted countries, UNFPA aided 265 schools in 2015, which is 24 per cent of the total number of schools in MHTF-supported countries.
3. By the end of 2015, seven new MHTF-supported countries – Bangladesh, Burundi, Cameroon, Haiti, Liberia, Mauritania and Togo – had incorporated a national costed midwifery workforce plan in the national human resources for health plan, increasing the total percentage of countries from 41 per cent (16 countries) to 59 per cent (23 countries).
4. Between 2009 and 2015, UNFPA, through the MHTF, supported 48 national and over 176 sub-national midwifery associations. All countries assisted by the MHTF now have a midwifery association dedicated to advocating for and scaling up the profession.

Partnerships

Enhanced Civil Society and Private Sector Partnerships

Global agreements signed with Jhpiego and Laerdal Global Health

In 2015, UNFPA and Jhpiego signed a new global memorandum of understanding on further strengthening global collaboration on maternal health and midwifery education and advocacy; this will further reinforce MHTF efforts.

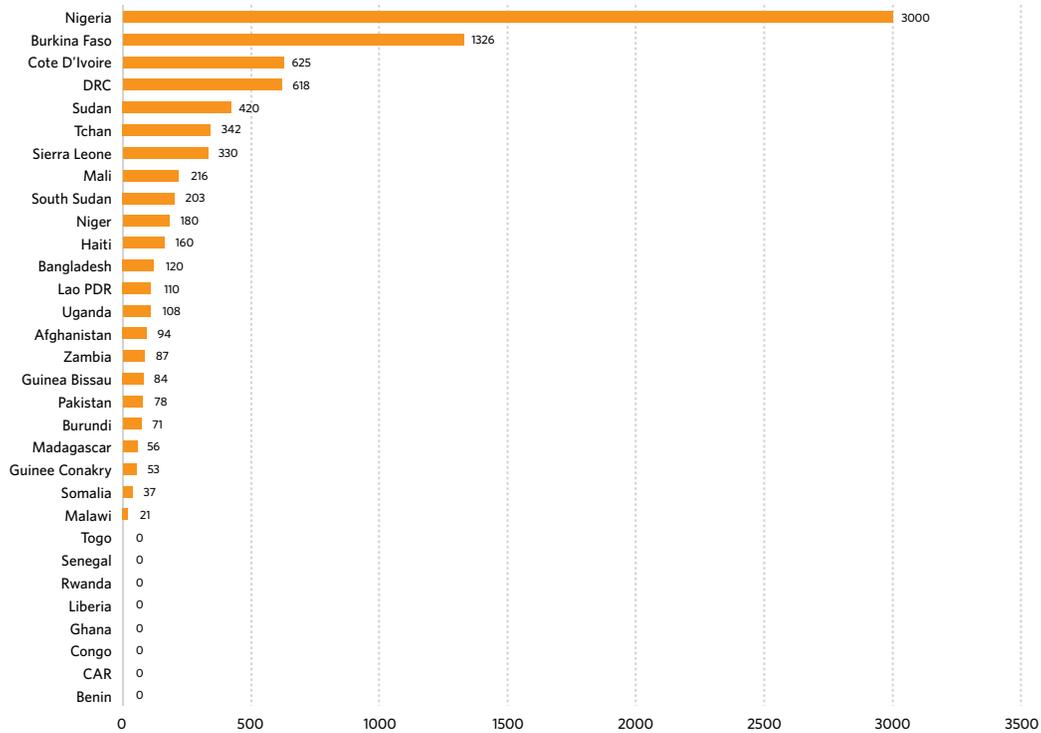
An in-kind agreement was signed with Laerdal Global Health on the provision of Mama and NeoNatalie midwifery training models in MHTF-supported countries, helping midwives to develop skills in post-partum haemorrhage and neonatal resuscitation management.

Second Phase of Joint Collaboration with the International Confederation of Midwives

The focus of this collaboration is on 22 Francophone African countries, therefore leveraging MHTF support to countries that do not receive direct MHTF assistance but could benefit from it. In 2015, the International Confederation of Midwives completed gap analysis in 17 countries through three workshops that also focused on the latest evidence-based midwifery and facilitated South-South exchanges.

Representatives from MHTF-supported West African countries (Benin, Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo and Togo) participated in a second regional workshop for West Africa jointly organized by UNFPA, WHO, the World Bank and the West African Health Organization. The objective was to help strengthen regional collaboration on the quality of midwifery education, promote strong South-South exchanges, and intensify efforts for education and harmonized regulation.

Figure 2.5: Number of midwives trained in pre-service training through the MHTF in 2015



Global Initiative to Engage Midwives and Other Health Workers in FGM/C Elimination

In Mauritania, the National Association of Midwives has publicly declared its opposition to FGM/C. Members pledged to abandon the practice in the communities they serve.

The UNFPA-UNICEF Joint Programme on FGM/C in 17 countries, of which 13 are MHTF-supported countries, and the UNFPA Midwifery Programme came together in 2015 to mobilize midwives

in the Campaign to End FGM/C. Given the increasing trend of the medicalization of the practice, where roughly 20 per cent (in some countries as high as 74 per cent) of cases are performed by trained health workers, it is essential to strengthen the capacity of midwives to resist social and economic pressure to perform FGM/C, improve care for girls and women who have undergone FGM/C, and serve as champions in FGM/C prevention. The initiative aims to:

1. Reduce the number of midwives performing FGM/C, including reinfibulation, by 50 per cent;

2. Double the number of midwives trained on FGM/C prevention and care;
3. Strengthen the capacity of midwives to serve as champions in FGM/C prevention;
4. Engage midwifery associations in the 17 target countries in the global campaign to end FGM/C;
5. Increase the awareness of policy makers on the role midwives play in FGM/C prevention and care;
6. Ensure that in target countries, FGM/C prevention and care is integrated in the midwifery curriculum; and
7. Increase the number of girls and women receiving prevention and care services.

During 2015, UNFPA advocated for FGM/C prevention at major international fora, such as the International Federation of Gynecology and Obstetrics World Congress and the global Maternal Health Conference, and organized a large number of national trainings for midwives to engage in eliminating this harmful practice.

E-Learning module on FGM/C prevention for midwives and other frontline health workers

To stem the growing medicalization of FGM/C, UNFPA developed a new FGM training module under the midwifery e-learning series to educate midwives on the human rights violations and health complications of FGM/C, and helps strengthen their capacity to serve as champions of prevention. In 2015, over 1,000 midwives used the e-learning module in several Arab and African countries.

In **Nigeria**, 83 trained health providers are now active as community-based advocates and counsellors; they have provided information on FGM/C to over 515 women.

In **Guinea**, 146 midwives from 65 health facilities created plans of action to implement in the communities they serve. In **Ethiopia** 254 midwives took part in a two-day training organized by the Ethiopia Midwifery Association. In **Burkina Faso**, 456 students from the National School of Public Health of Ouagadougou and two private schools completed the training and signed a pledge to prevent FGM/C.

Evidence-Based Advocacy

International Day of the Midwife

On 5 May 2015, UNFPA globally supported the celebration of the International Day of the Midwife under the slogan, “Midwives for a Better Tomorrow.” This was done in collaboration with national midwifery associations, ministries of health, civil society groups and UN partners, among other relevant stakeholders.

Colourful public marches by midwives, intense public debates, radio and television talk shows and newspaper articles, and free family planning as well as screening camps for HIV, sexually transmitted infections, and breast and cervical cancer helped shine a spotlight on key midwifery issues and policies and the positive role that midwives play in promoting maternal and newborn health in communities.

In **Burkina Faso**, the day was commemorated under the patronage of the Minister of Health. In preparation, 40 midwives in the South Central region received training on the Implanon and Sayana Press contraceptives, and 200 midwives were trained on respectful maternity care. On the day itself, free breast and cervical screening campaigns were organized for 534 women; 62 received free family planning services, including 22 new users.

Launch of the French Lancet Midwifery Series was done jointly by the International Confederation of Midwives, UNFPA and WHO in Geneva. An abstract is available [here](#).⁷

⁷ <http://bit.ly/2bLf8NU>

Wilson Center, Maternal Health Dialogues

The MHTF continued its support to the Wilson Center, a top think tank in the United States, to conduct high-profile maternal health dialogues and debates among policy makers, civil society and intellectuals. Notable among these were dialogues on midwifery, maternal morbidities, incorporating mental health in maternal health, and engaging health workers, particularly midwives, in the elimination of FGM/C. All events were webcast and archived on the Wilson Center website.

“We must do more. And we must start with training and providing more midwives. Evidence shows that midwives who are educated and regulated to international standards can provide 87 per cent of the essential care needed by women and their newborns.”

“Today, we call for greater investments to increase the number of midwives and enhance the quality and reach of their services. Strong political commitment and investment in midwives is needed to save millions of lives every year.”

Statement by Dr. Babatunde Osotimehin, Executive Director, UNFPA, on the International Day of the Midwife in 2015



International Day of the Midwife 2015 celebration in Uganda. © Evelyn Matsamura Kiapi, UNFPA.

UNFPA Midwifery Symposium “Call the Midwife: A Conversation about the Rising Global Midwifery Movement”

A one-day high-profile Midwifery Symposium was organized by UNFPA and the Wilson Center in Washington, DC in collaboration with the Government of Sweden. It brought together eminent speakers from across the maternal health community, and approximately 80 experts, programme managers, practitioners and donors. Participants learned about the latest evidence on midwifery and various global midwifery initiatives, reflected on select country midwifery experiences, and discussed innovative approaches and cost-effective technologies for scaling up midwifery capacities, including through public-private partnerships.

Conclusion

Between 2009 and 2015, UNFPA through the MHTF supported countries in training 58,000 midwives, including through pre- and in-service trainings. However tracking the deployment of these midwives has been challenging. This underscores the need to collect relevant data to track impacts. One way to do so would be for midwives to be registered and regulated. UNFPA will keep supporting midwifery associations to play a major role in policy advocacy for this and other goals.

Investment in midwifery is critical for achieving the SDG targets of ensuring universal access to sexual and reproductive health care, and ending preventable maternal and newborn mortality. Yet major gaps remain in the availability and accessibility of midwifery services. Many women continue to shy away from services, even when they are available, because of the lack of respectful and quality care. In many cases, services are still not available where most needed, and the overall health system, regulatory mechanisms and supportive environment are weak.

UNFPA nonetheless has achieved good results in 2015 and plans to keep pushing the midwifery agenda forward to improve maternal and neonatal health.



A patient referred for emergency obstetric and neonatal care in Rwanda in 2015.

©Salim saidi Bucyanayandi, UNFPA. Photo submitted by Mathias Gakwerere for MHTF Annual Report 2015 photo contest.

3 | EMERGENCY OBSTETRIC AND NEWBORN CARE

HIGHLIGHTS

The MHTF supports countries to strengthen the availability and quality of maternal and newborn health services with a specific focus on the effective planning, development and monitoring of a national emergency obstetric and newborn care (EmONC) facility network. In addition to helping countries conduct national emergency obstetric and newborn care needs assessments and develop costed plans for improving service availability and quality, the MHTF promotes the regular monitoring of data to drive responsive and needs-based decisions and actions, and to limit country dependencies on expensive ad hoc national surveys. Key results in 2015 included:

- **Three countries (Lesotho, Malawi and Timor-Leste) completed a national emergency obstetric and newborn care needs assessment survey** to develop a costed national plan; **Zambia is finalizing its assessment. Since 2010, the MHTF has supported 24 countries** (61 per cent of MHTF-assisted countries) **to complete assessments, and 14 have subsequently developed and implemented costed national plans.**
- **Two countries (Madagascar and Togo) went beyond a needs assessment and initiated, with MHTF support, national monitoring of the availability and quality of maternal and newborn health services in emergency obstetric and newborn care facilities. In 2015, eight countries (Burundi, Haiti, Lao People's Democratic Republic, Nepal, Niger, Sierra Leone, Timor-Leste and Togo) collected maternal and newborn health data in these facilities on a regular basis.**
- **Burundi became the first MHTF-supported country to report reaching the minimum international standard of five functioning emergency obstetric and newborn care facilities per 500,000 people.** Nepal has reported reaching 70 per cent of the minimum international standard.
- **Four countries (Haiti, Niger, Sierra Leone and Togo) can track the number of midwives and other health professionals working in emergency obstetric and newborn care facilities.** This information helps them effectively deploy qualified midwives.
- **The MHTF has further integrated its work on emergency obstetric and newborn care and midwifery by supporting 52 accredited basic care training centres linked to midwifery schools in seven countries.** These strengthen the quality of the training of midwives and effectively prepare them to manage basic care facilities.
- **Globally, the MHTF supported the development of the Ending Preventable Maternal Mortality core list of maternal health indicators for global monitoring and reporting by all countries.** The list was finalized in October 2015 for endorsement by countries at the World Health Assembly in May 2016.

The MDGs called for reducing the maternal mortality ratio by two-thirds from 1990 to 2015, but only a few countries reached this target. The new SDG target on maternal health is even more ambitious, with global maternal mortality to be reduced to less than 70 per 100,000 live births, and for no country to have a maternal mortality ratio above 140 per 100,000 live births by 2030. Countries need to implement targeted high-impact strategies and interventions, including sufficient emergency obstetric and newborn care facilities that offer integrated sexual and reproductive health services, efficient referral between facilities, and continued monitoring of emergency obstetric and newborn care networks to ensure and improve quality. The MHTF actively supports countries to innovate in implementing these interventions.

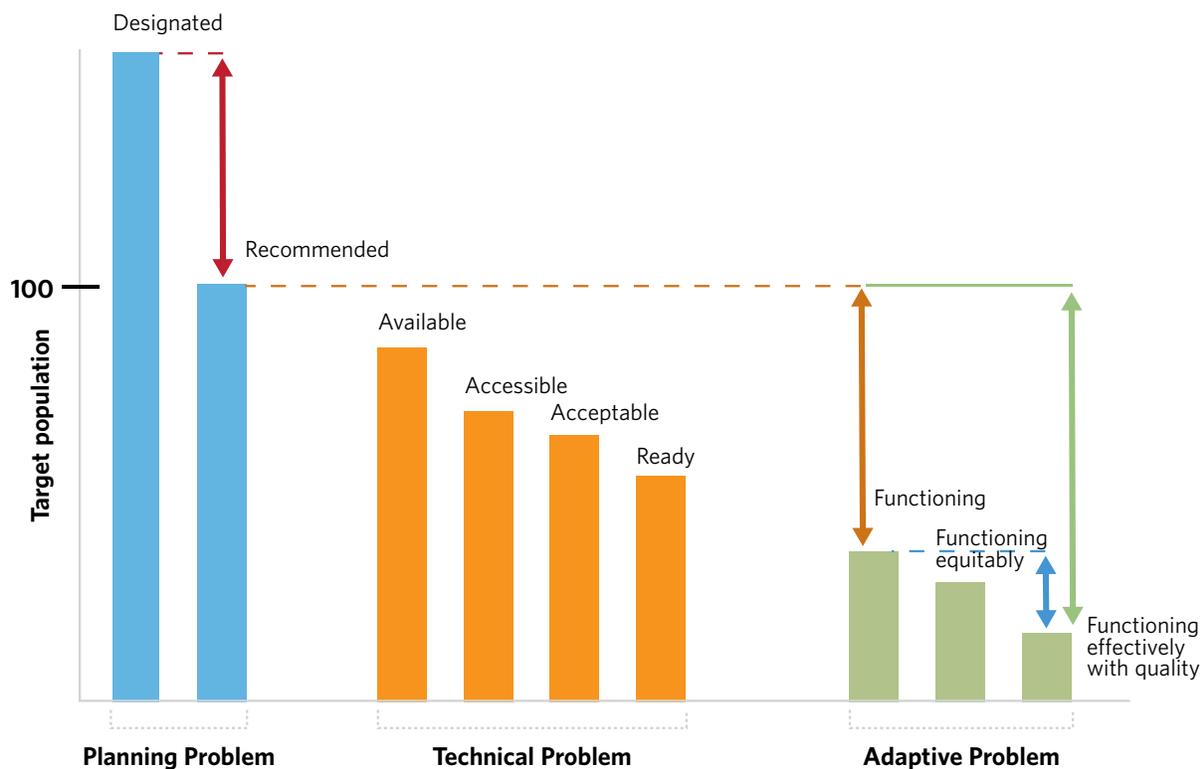
The reduction of maternal and newborn mortality can be accelerated by enhancing access to quality emergency obstetric and newborn care services in designated facilities. As highlighted by the *Countdown to 2015* report, countries

with high maternal and newborn mortality are far from achieving the minimum standard of five facilities per 500,000 inhabitants.⁸ In many countries, access to quality emergency care remains a major challenge for pregnant women as the development of a functioning facility network is impeded by limited strategic planning and monitoring of services, and the scarcity of skilled birth attendants. Cooperation and teamwork among obstetricians, anesthetists and midwives is another key driver for a functioning network. Staff should be able to interact and analyse their responses and performance to provide the best possible health care.

Averting Maternal Death and Disability, the MHTF’s strategic partner in emergency obstetric and newborn care development, has conducted a review of needs assessments since 2005. These highlight serious obstacles in planning facility networks, with a common situation summarized in Figure 3.1.

⁸ *Countdown to 2015*, Annex E.

Figure 3.1: Emergency obstetric and newborn care coverage by problem type based on a review of needs assessments since 2005



Source: Lynn Freedman, *Averting Maternal Death and Disability*, Columbia University, New York.

In countries with the highest burden of maternal mortality, there is a gap between the population covered by facilities identified for eventual emergency obstetric and newborn care upgrading, and the minimum number of functioning EmONC facilities recommended by international standards (red arrow). **There is another gap between the number of recommended and functioning EmONC facilities (brown arrow). This gap reflects the implementation challenges that most countries face in delivering maternal and newborn services, which dramatically impact capacities to manage obstetric and neonatal emergencies, and help explain why the MDG target was mostly not achieved.** Further, while an emergency obstetric and newborn care facility may be considered as functioning, this does not necessarily imply satisfactory quality of care. This gap (indicated by the blue arrow) is very challenging and requires the attention of all stakeholders. The goal of the MHTF is to reduce all three of these gaps (green arrow).

In addition to supporting needs assessments and monitoring of emergency obstetric and newborn care facilities in countries, globally, the MHTF has supported the development of maternal health indicators for monitoring and reporting by all countries, the revision of needs assessment tools, and guidance for maternal and newborn health monitoring in facilities.

Testing and measuring both coverage and performance of interventions for emergency obstetric and newborn care development are likely to facilitate the achievement of the SDG maternal mortality target. With MHTF support, Madagascar and Togo have taken strategic decisions to reduce planning and implementation gaps in emergency obstetric and newborn care facilities as described in further detail later in this chapter.

Country Highlights

Emergency obstetric and newborn care development comprises 18 per cent of the MHTF budget allocated to countries. Activities to improve data availability, the monitoring of maternal and newborn services, and emergency obstetric and newborn care facility development represent 5 per cent of the budget to countries. Due to limited funding, the MHTF at the global and regional level and its partner Averting Maternal Death and Disability only provided remote technical support to **Lesotho** and **Timor-Leste** needs assessments in 2015. With MHTF support,

Averting Maternal Death and Disability directly supported the needs assessment in **Malawi**, and **Zambia** is in the process of finalizing its own.

Needs assessments serve as a baseline for the full development and implementation of an EmONC facility network (situation analysis, planning, implementation, and maternal and newborn health monitoring). They support data-driven, result-based management of the maternal health programme, as shown in Haiti, Madagascar and Togo, where the Ministry of Health and international partners took part in a coordinated way. More investments need to be targeted to such activities.

Developing emergency obstetric and newborn care facility networks, in particular basic EmONC facilities as pre-service training centres for midwives, represents 7 per cent of the MHTF budget. This activity has huge leverage effects when health facilities benefit from well-trained midwives and provide satisfactory quality of care in obstetrics, including the capacity to manage basic emergency situations.

Fostering the integration of services, in particular, midwifery and family planning, immunization and eliminating mother-to-child transmission of HIV, and improving quality of care, absorb 6 per cent of the MHTF budget allocated to countries. This support should increase in the near future, in particular through mentorship programmes for providers in emergency obstetric and newborn care facilities.

Needs Assessment in Malawi

Malawi is one of the poorest of the MHTF-supported countries, but has a maternal mortality rate comparable with those in Cameroon and Côte d'Ivoire. Efforts are being made to develop an emergency obstetric and newborn care facility network in all districts. In 2015, **Malawi** was the only country that completed an EmONC needs assessment, supported by the MHTF as well as UNICEF, USAID, the Clinton Foundation Initiative and Save the Children. Initiated in 2014, the assessment follows a previous one conducted in 2005, with the evolution of emergency obstetric and newborn care indicators summarized in Table 3.1.

Table 3.1: Indicators in 2005 and 2015 needs assessments in Malawi

	Needs assessment 2005	Needs assessment 2015
Population	12 million	15 million
Recommended basic emergency obstetric and newborn care facilities	96	126
Recommended comprehensive emergency obstetric and newborn care facilities	24	32
Functioning basic emergency obstetric and newborn care facilities	2	19
Functioning comprehensive emergency obstetric and newborn care facilities	42	45
Emergency obstetric and newborn care availability (according to international standards)	36%	40%
Proportion of deliveries in functioning emergency obstetric and newborn care facilities	19%	24%
Emergency obstetric and newborn care met needs	18%	25%
C-section rate in functioning emergency obstetric and newborn care facilities	2.8%	3%
Direct obstetric case fatality rate in functioning emergency obstetric and newborn care facilities	3.4%	1%
Intrapartum and very early neonatal deaths (per 1,000 deliveries)	-	20

In 10 years, the number of functioning emergency obstetric and newborn care facility increased very slowly from 36 per cent to 40 per cent. Some efforts have been made to develop more Basic EmONC facilities, but Malawi has built its response on developing Comprehensive EmONC facilities. The 19 Basic EmONC facilities are not enough to improve facility coverage. Despite the fact that 45 functioning Comprehensive EmONC facilities exceed by far the international standard recommendation (32 facilities), the C-section rate (3 per cent) remains far below the minimum standard (5 per cent). During this period, quality of care appears to have improved, as the direct obstetric case fatality rate declined from 3.4 per cent to 1 per cent.

Togo on Its Way to Success

Since 2012, Togo has implemented evidence-based interventions to improve the availability and quality of emergency obstetric and newborn care services. For the last four years, the MHTF has provided strategic support for improving the facility network as well as data-driven processes to address gaps in availability and quality of maternal and newborn health services. MHTF support in Togo is a clear illustration of the catalytic effect that the MHTF has, as the network is co-financed by the Ministry of Health and other trust funds, such as the Multilateral Muskoka Trust Fund.

In 2012, in light of the results and recommendations of the emergency obstetric and newborn care needs assessment supported by the MHTF and Averting Maternal Death and Disability, Togo decided to review its maternal health policy

and the development of its facility network to strategically deploy skilled human resources and supplies, and ensure the effective availability and quality of services in all six of its regions.

In 2013, with MHTF support, the Ministry of Health prioritized a reduced number of facilities to provide emergency obstetric and newborn care services as a first step towards build a functioning facility network. Using internationally agreed criteria and in-depth analysis of health facilities in the country, 71 facilities were targeted to be Basic EmONC facilities, and 38 to be Comprehensive EmONC facilities.

In 2014, Togo launched the quarterly monitoring of maternal and newborn health services in designated emergency obstetric and newborn care facilities, and, following MHTF advice, initiated trainings and materials for vacuum extraction and newborn resuscitation. In 2015, Togo also became one of the first countries in sub-Saharan Africa to define the mission, role and operating model of a basic emergency obstetric and newborn care facility within the health system. This national framework of reference aims to guide health providers as well as national and sub-national stakeholders to address gaps in the availability and quality of services.

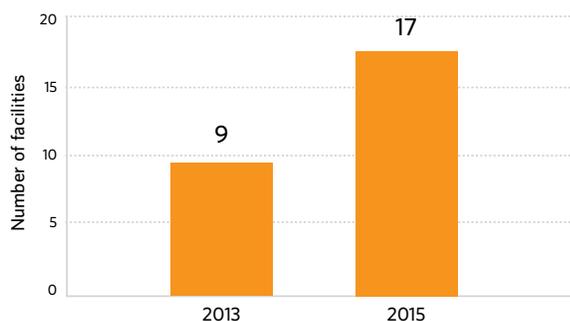
As a result, more than 100 new midwives were placed in the EmONC facility network in 2015, especially in Basic EmONC facilities. From 2013 to 2015, as shown in Figure 3.2, the number of functioning EmONC facilities in Togo



Newborn care in a basic EmONC facility in Haiti. ©UNFPA.

almost doubled (from 9 in 2013 to 17 in 2015). Many other facilities could become functional Basic EmONC facilities if more midwives could be deployed, allowing round-the-clock maternal and newborn health services. While magnesium sulfate and IUDs were only introduced in the health system in 2012, 88 per cent and 51 per cent of emergency obstetric and newborn care facilities had supplies of magnesium sulfate and Intrauterine Devices (IUD), respectively, in the last quarter of 2015. Similarly, while vacuum extractions were in limited use before 2014, 47 per cent of EmONC facilities performed them during the last quarter of 2015. The quarterly monitoring of maternal and newborn health services allows national and sub-national stakeholders to follow progress on a regular basis and define targeted responses to address regional gaps.

Figure 3.2: Number of functioning Basic EmONC facilities in Togo

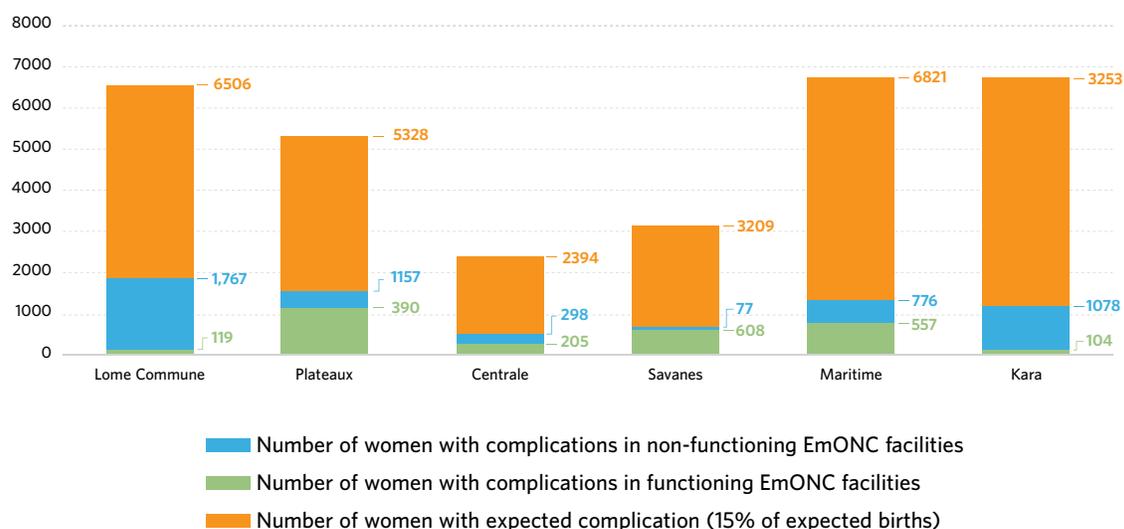


Source: Emergency Obstetric Newborn Care Needs Assessment 2012, and maternal and newborn health monitoring data from the third and fourth quarters of 2015.

Monitoring also shows that the number of births in functioning emergency obstetric and newborn care facilities and the “met” need for care have increased in three regions since 2012 (Savane, Maritime and Kara). While the target for “EmONC met need” is 100 per cent, there is no specific target for the number of births in functioning EmONC facilities. The strategic interventions implemented in Togo to improve the availability and quality of services and referral linkages between facilities, however, are expected to contribute to increased coverage of births in functioning EmONC facilities. In two other regions (Centrale and Plateaux), the number of births in functioning EmONC facilities and the “EmONC met need” have decreased since 2012. These regions have two combined issues: an important deficit of midwives deployed in the EmONC facility network, and a number of designated EmONC facilities much higher than the recommended minimum, leading to the dispersion of limited available resources across numerous facilities.

As illustrated in Figure 3.3, the functioning EmONC facility network only covers 11 per cent of expected obstetric complications, still far away from the target of 100 per cent. Monitoring also highlights additional disparities among regions. While 19 per cent and 22 per cent of expected complications are managed in functioning EmONC facilities in Maritime and Plateaux, respectively, the same figures are only 2 per cent and 3 per cent in Lome Commune and Kara, respectively. Such results call for urgent actions to improve the access, availability and quality of services in all regions – specifically by further prioritizing the number of EmONC facilities, by optimizing their positions, by ensuring the availability and quality of skilled human resources and supplies, and by improving referrals among facilities, and between them and other facilities with obstetric activities that should refer complications to the EmONC facility network.

Figure 3.3: Number of women with direct obstetric complications in functioning and non-functioning emergency obstetric and newborn care facilities

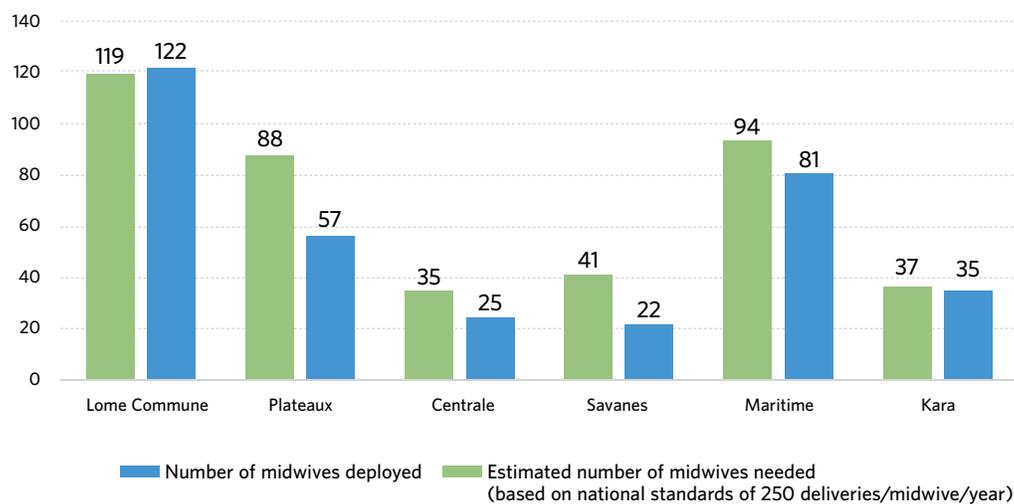


Source: Maternal and newborn health monitoring data from the third and fourth quarters of 2015.

As a consequence of limited access to quality services, 91 maternal deaths occurred in emergency obstetric and newborn care facilities, with an average direct obstetric complication rate of 1.2 per cent. On average, only 3 per cent of women accessed family planning within 48 hours after delivery. Togo is one of the few countries in sub-Saharan Africa able to regularly monitor this indicator, and therefore has the capacity to effectively address it.

A first priority identified by the Ministry of Health is the deployment of additional midwives in the facility network, given a deficit of 80 midwives, with substantial differences among regions (Figure 3.4). Twenty additional functioning Basic EmONC facilities could be immediately available if more midwives were recruited to provide round-the-clock services there.

Figure 3.4: Number of midwives deployed in the EmONC facility network in Togo compared to the international norm (green)



Source: Maternal and newborn health monitoring data for the third and fourth quarters of 2015.

Despite some challenges in the completeness and quality of data, the monitoring of maternal and newborn health services in emergency obstetric and newborn care facilities

constitutes a powerful resource for the Ministry of Health, and could drive decisions on service availability and quality. From July to December 2015, in the six regions, 56 ob-gyn

doctors, 344 midwives and 106 anesthesiologists took care of 35,439 deliveries, with 7,136 direct complications and 2,232 neonatal resuscitations.

Rapid Assessment and Monitoring in Madagascar

Inspired by approaches in Burundi, Haiti and Togo, the MHTF at the global and regional levels encouraged the Madagascar Ministry of Health, UN agencies and USAID to review the emergency obstetric and newborn care development policy and prioritize improvements in a reduced number of facilities to be upgraded to EmONC facilities. In 2015, key maternal and newborn health stakeholders at national and sub-national levels designed a national monitoring tool to be implemented in all regions by the Ministry, supported by the H4+ partnership (including USAID and Agence Française de Développement).

In November 2015, the monitoring tool was used in one province, Atsimo Andrefana (with approximately 1.4 million

inhabitants), for a rapid assessment to update information on obstetric activity. Based on this, a regional process initiated the selection of facilities for the regional emergency obstetric and newborn care network, including three comprehensive and 11 Basic EmONC facilities.

In early 2016, the same process will be implemented in other regions with assistance from international agencies, offering another illustration of how the MHTF can leverage support.

Despite progress made in developing emergency obstetric and newborn care services, a significant change is still needed to reach the ambitious SDG target on maternal health. To increase the number of functioning Basic EmONC facilities and the quality of care, the MHTF recommends upgrading a reduced number of selected facilities to Basic EmONC facilities within existing resources, and monitoring the facility network on a regular basis. Stronger attention should be given to midwives' education and deployment in order to further improve the quality of care in Basic EmONC facilities.



Obstetric Map - Atsimo Andrefana region

Health Facilities

- Designated EmONC facilities [11]
- One EmONC facility must be created (no infrastructure)
- ★ Designated EmONC facilities[2]
- ★ CHU: Hospital Tanambao (Toliara I) Designated EmONC [1]

Districts and remote areas

- Districts with designated EmONC facilities
- Remote & densely populated area from the South coast
- Remote and populated district
- Remote and unpopulated districts

Referral links from B-EmONC to C-EmONC

- Good referral conditions
- Difficult referral conditions
- Very difficult referral conditions
- ▲ Private medical center where C-section is performed: other possibility for referral

Global and Regional Highlights

The Ending Preventable Maternal Mortality Group and Maternal Health Core Indicators

MHTF advisers represent UNFPA in the Ending Preventable Maternal Mortality Working Group, a coordination mechanism supported by WHO, UNFPA, USAID, UNICEF and Jhpiego. In 2015, the group agreed on a core set of methodologically robust maternal health indicators with direct relevance for reducing preventable mortality (proximal to causes of death) for global monitoring and reporting by all countries. The MHTF successfully advocated for the inclusion of “emergency obstetric and newborn care availability” and “emergency obstetric and newborn care met needs” indicators in the core list.

Needs Assessments Tools Reviewed

In late 2015, Averting Maternal Death and Disability, with support from the MHTF, held a technical meeting to synchronize and finalize revisions of its tools, new versions of which were shared with UNICEF, WHO, the Jhpiego, USAID and Saving Newborn Lives. The tools give more emphasis to newborn health. A Data Analysis Guide has been thoroughly revised with updated content.

A new reporting format for emergency obstetric and newborn care needs assessment that is more conducive to national planning has been elaborated.

Maternal and Newborn Health Monitoring

In a 2015 MHTF survey of maternal health activities in countries it assists, 21 countries indicated that they are monitoring maternal and newborn health services, but only 4 were able to provide 2015 figures for the number of functioning emergency obstetric and newborn care facilities and the number of midwives working in designated facilities. This limited management of the maternal and newborn health programme jeopardizes the development of Basic EmONC facilities as referral centres for emergency care.

The development of guidance for maternal and newborn health monitoring in emergency obstetric and newborn care facilities has been initiated by the MHTF, with contributions from UNFPA’s maternal health advisers from the four countries most advanced in implementing monitoring (Burundi, Haiti, Madagascar and Togo). Once finalized, the document will be shared with UNFPA

country offices in other MHTF-supported countries to assist prioritization and monitoring.

In 2015, the MHTF developed guidance on two additional innovative approaches: implementation science and geographic information systems (GIS), with the aim of optimizing maternal and newborn health services monitoring. Lessons learned will be documented for use in other health programmes and sectors. Implementation science has been used for many years in business, manufacturing, education, health and social sectors in high-income countries for sustainable implementation of innovations in systems and organizations. GIS can map facility networks and improve their development

Tapping innovation to advance maternal health services

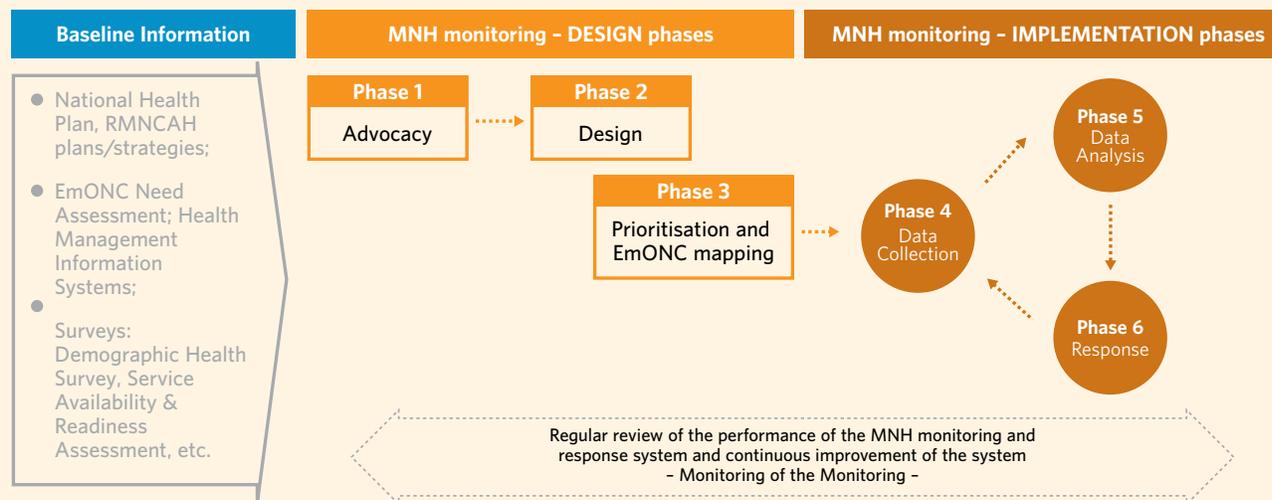
Implementation science is defined as “a specified set of activities designed to put into practice an activity or program of known dimensions.” It seeks to identify drivers for the sustainable uptake, adoption and implementation of evidence-based interventions. These drivers include: (1) competency drivers (e.g., staff selection, pre-service and in-service training, ongoing coaching/mentorship, data-supported decision-making); (2) organizational drivers (e.g., facilitative administration, adaptive/flexible processes and operating procedures, information exchanges); and (3) leadership drivers (e.g., support for proactivity and staff initiatives). Evidence from implementation science in high-income countries shows that implementation teams, organizations and staff leverage the implementation drivers and tend to increase the success of innovations from around 5 per cent to 15 per cent to as much as 60 per cent to 80 per cent.

Geographic Information Systems allow the display and analysis of population density, road networks, administrative boundaries, health infrastructure and physical characteristics of a region, among other elements. As the location of emergency obstetric and newborn care facilities is a key determinant of access to services, the application of GIS to maternal and newborn health is critical for identifying geographic and transportation barriers for women.

Overview of maternal and newborn health monitoring in emergency obstetric and newborn care facilities

The monitoring of maternal and newborn health services in emergency obstetric and newborn care facilities allows the regular (e.g., quarterly) collection and analysis of key data, and facilitates responsive and needs-based decisions and actions at all levels of the health system to improve service availability and quality. It reduces country dependence on expensive ad hoc surveys.

Monitoring should typically follow an emergency obstetric and newborn care needs assessment in order to build on its momentum and use its data as a baseline for the development of the facilities network. The setup of monitoring includes six key phases shown in the following figure.



Conclusion

Experience in emergency obstetric and newborn care development demonstrates the importance of a comprehensive planning cycle for efficient management. Every stage is important, from the situation analysis or needs assessment to the definition of strategic orientations to a costed plan, followed by implementation and monitoring.

The MHTF will continue to support countries that have made the strategic choice to develop an effective emergency obstetric and newborn care facility network with more Basic EmONC facilities that bring good quality maternal and newborn care closer to pregnant women. One of the most challenging decisions is to prioritize which health facilities could offer emergency obstetric and newborn care, and progressively aim for the minimum international standard of five per 500,000 inhabitants.

The MHTF will also support pre-service training for midwives by assisting the development of accredited training centres in functioning basic emergency obstetric and newborn care facilities, with a special focus on quality of care and educational science.

Experiences in Togo and other countries confirm the importance of regular measurement of gaps for the ministry of health to continuously adjust the maternal health programme.

Implementation remains a major challenge for maternal health programming. The MHTF will work with countries to explore possibilities from implementation science. Leveraging competency, organizational and leadership drivers to foster local solutions and staff empowerment should contribute to the development of emergency obstetric and newborn care networks that provide high-quality maternal and neonatal health care in a sustainable manner.



Mothers in Bagram, Afghanistan.
©Eric Kanalstein, United Nations.

4 | MATERNAL DEATH SURVEILLANCE AND RESPONSE

HIGHLIGHTS

The MHTF supports countries to implement maternal death surveillance and response systems.

Key results in 2015 included:

- More than half of MHTF-supported countries had national maternal death surveillance and response systems in place.
- All MHTF-supported countries had a complete or partial maternal death surveillance and response policy framework.
- Nine countries had a policy framework with a national costed plan, mandatory notification, WHO customized tools and guidance, and a functioning national maternal death surveillance and response committee. Twenty-four countries had a partial policy framework.
- Despite progress, implementation and coverage were still limited. Only six countries had a maternal death notification rate in facilities above 20 per cent; only one country had a rate above 40 per cent.
- Only 26 per cent of MHTF-assisted countries issued a maternal death surveillance and response annual report.

According to UN estimates,⁹ over 200,000 maternal deaths occur every year in MHTF-supported countries. Most are due to preventable causes,¹⁰ emphasizing the critical need for every maternal death to be registered and reviewed. A maternal death surveillance and response system helps understand the underlying causes of each death and guide responses to potentially eliminate preventable maternal deaths in the future.

Findings from maternal death surveillance and response can improve quality of care and provide powerful evidence to influence actions and decisions among policy and decision-makers, non-governmental organizations and communities

⁹ Trends in maternal mortality: 1990 to 2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division

¹⁰ Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels JD, et al. Global Causes of Maternal Death: A WHO Systematic Analysis. *Lancet Global Health*. 2014;2(6): e323-e333.

Country Highlights

Support to maternal death surveillance and response system development comprises 9 per cent of the MHTF budget allocated to countries. This includes:

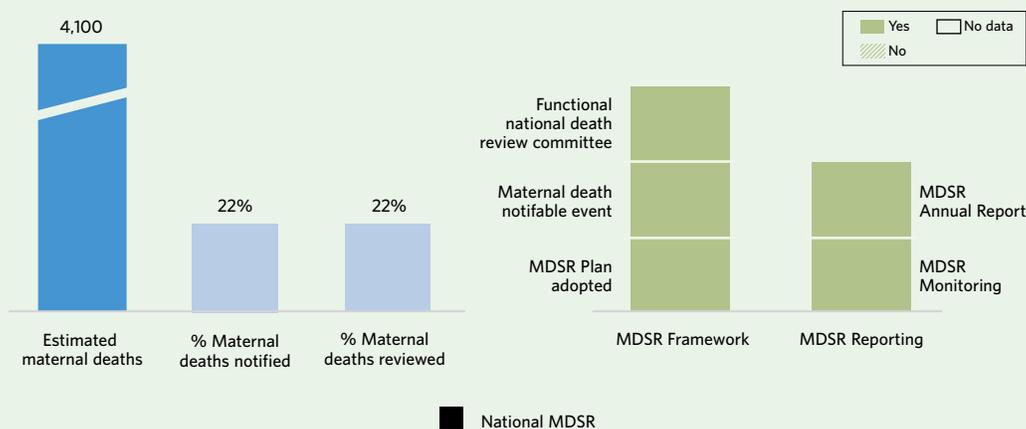
- 2 per cent to supporting programme framework development and coordination mechanisms;
- 3 per cent to supporting system capacities to report and analyse maternal deaths, monitor coverage and organize responses based on findings; and
- 4 per cent to supporting implementation in facilities and districts.

Sudan

The maternal mortality ratio in Sudan decreased from 744 per 100,000 live births in 1990 to 311 in 2015,¹¹ but the country did not reach its MDG 5 target. A maternal death surveillance and response system could further improve the quality of care and health system performance and was initiated in 2009, yet still needs to be fully implemented.

In 2014, according to a 2015 survey by WHO, and UNFPA through the MHTF, all 922 identified maternal deaths were reviewed (Figure 4.1), and among them, 16 per cent were registered at the community level. This situation is unusual, since many countries lack community maternal death notification and review only a small proportion of notified deaths. Sixty-three per cent of the deaths were related to the first delay (time spent at the community level before seeking care in a facility), and 56 per cent of these women did not attend antenatal care. This suggests that more work should be done at the community level, among both women and men, to disseminate information about the importance of antenatal visits and the signs of complications during pregnancy. Another priority is to increase the proportion of deaths that are registered and reviewed.

Figure 4.1: A profile of the maternal death surveillance and response system in Sudan



¹¹ Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization, 2015.

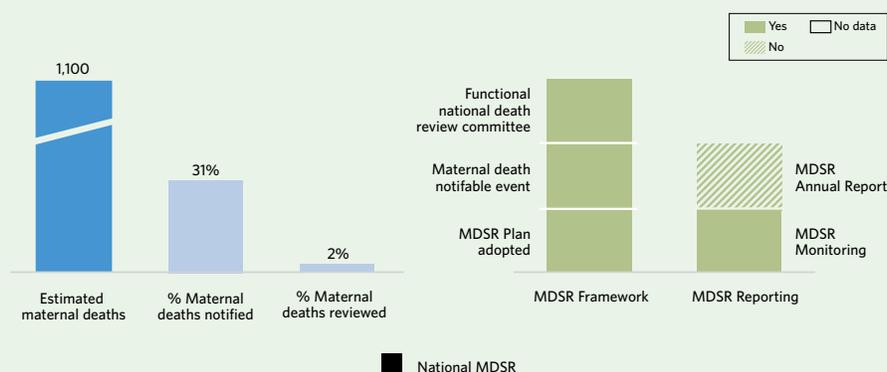
Rwanda

Rwanda has significantly decreased its maternal mortality ratio from 1,300 deaths per 100,000 live births in 1990 to 290 [Confidence Interval 208-389] in 2015,¹² becoming one of the few countries to attain the MDG 5 target.¹³ To reach the challenging new SDG target for maternal mortality, the Ministry of Health needs to improve the quality of maternal and newborn services, including through developing a maternal death surveillance and response system.

The policy framework is now in place, but no annual report was produced in 2015 (Figure 4.2). Key challenges include the accuracy of information (limited medical records, incomplete medical files), high staff turnover, and challenging communication between health centres and district hospitals. Follow-up on recommendations and timely feedback at the district and national levels remain weak.

The current 31 per cent notification rate is high for sub-Saharan Africa, yet too low to reflect a strong maternal death surveillance and response system or to analyse maternal mortality trends. It does not reflect the Ministry of Health's ambition to reduce the maternal mortality ratio below 100 deaths per 100,000 live births. The portion of maternal deaths reviewed is still very low, at less than 10 per cent.

Figure 4.2: A profile of the maternal death surveillance and response system in Rwanda



¹² Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization, 2015.

¹³ Ibid., p. 28

Global Highlights

Global Events

Both the International Federation of Gynecology and Obstetrics Congress and the Global Conference on Maternal and Newborn Health hosted sessions on maternal death surveillance and response systems. The MHTF highlighted issues encountered in an increasing number of countries during implementation.

A working group on maternal death surveillance and response systems, comprising UNFPA, WHO, the Centers for Disease Control and Prevention, and USAID, agreed in 2015 that, notwithstanding the need to complete and strengthen the maternal death surveillance and response policy framework,

it should continue to support countries to monitor implementation processes and results. They highlighted the need to support countries on issues such as implementation of realistic goals. Other priorities are the elaboration of annual reports and national legal framework analysis.

The MHTF is now using the maternal death notification rate and proportion of maternal and newborn deaths reviewed to measure the performance of maternal death surveillance and response systems. According to 2014 and 2015 surveys, health system information on responses is still quite limited. The working group underlined close coordination to successfully support the development of maternal death surveillance and response systems.

Mozambique

The maternal mortality ratio of Mozambique has fallen from 1,390 deaths per 100,000 live births in 1990 to 489 [Confidence Interval 360-686] in 2015 (UN estimates, 1990-2015). Like many countries, Mozambique did not reach the MDG 5 target, but made significant progress. The maternal death surveillance and response framework is in place but faces issues with reporting and implementation on a national scale (Figure 4.3). As a result, the maternal death notification rate is low at less than 20 per cent of all maternal deaths. Nearly 90 per cent of notified cases are reviewed, however, a strong sign that the Ministry of Health is committed to maternal death surveillance and response as a routine practice.

In 2016, the MHTF will support the National Death Audit Committee with devising and implementing an annual operational plan and monitoring framework to ensure a significant increase in the maternal death notification rate.

Figure 4.3: A profile of the maternal death surveillance and response system in Mozambique

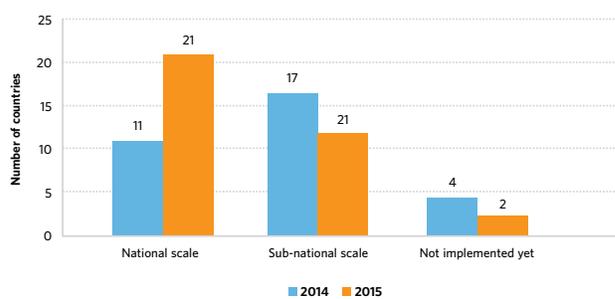


Surveys

To define the state of maternal death surveillance and response system development, WHO, and UNFPA through the MHTF conducted a survey in 2015, capturing 2014 data. Among 39 MHTF-assisted countries, only four - Guinea Conakry, Guinea Bissau, Liberia and Yemen - did not answer the questionnaire. Both Liberia and Yemen confronted very challenging domestic situations. Guinea Bissau had no system in place in 2014.

In April 2016, UNFPA conducted a MHTF survey to collect 2015 data. In each country, maternal health experts from WHO, UNFPA and the Ministry of Health responded to a French or English questionnaire. Information for 2015 is available for 35 countries (80 per cent of MHTF-supported countries). Cameroon, Kenya and Mozambique did not respond. Because of its unique situation, Yemen was not included. See Figure 4.4.

Figure 4.4: The scale of maternal death surveillance and response system implementation in 32 MHTF-supported countries

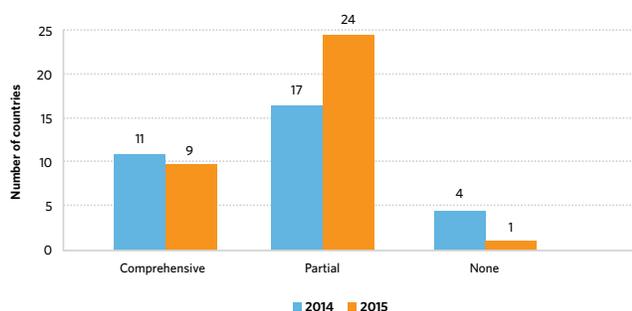


UNFPA fosters efforts to nationally scale up maternal death surveillance and response systems. In 2015, 10 more countries reached national scale (60 per cent of all MHTF-supported countries). Only two MHTF-assisted countries did not have a system yet.

A policy framework is important for maternal death surveillance and response system development. It is considered complete when it comprises a national plan, mandatory notification, WHO customized tools and guidance, and a functioning national maternal death surveillance and response system committee.

Figure 4.5 shows an apparent decrease in 2015, as “plan” criteria were strengthened. In 2015, the WHO, and UNFPA survey asked if countries had a maternal death surveillance and response system plan, whereas in 2014, countries were asked if they had a costed plan, which is more challenging to answer. Countries were accepted as “yes” if they claimed a costed plan and could provide a figure for the budget. In 2015, every MHTF-supported country had a complete or partial programme framework, compared to only four countries in 2014.

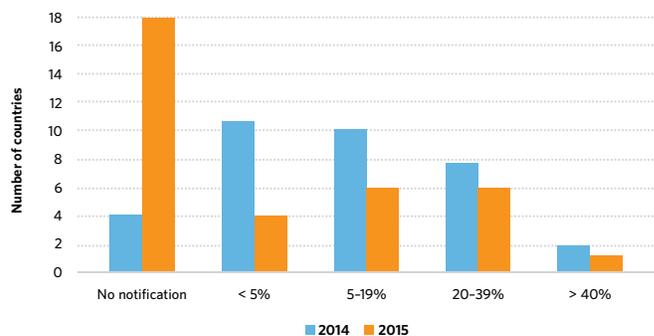
Figure 4.5: The state of the policy framework in 32 MHTF-supported countries



The MHTF adopted the notification rate (number of maternal deaths notified/expected maternal deaths) and proportion of maternal deaths reviewed as key indicators of programme coverage and performance. Keeping in mind the limitations of these indicators based on maternal death estimates, Figure 4.6 shows that most MHTF-assisted countries were still beginning implementation.

In most MHTF-assisted countries, the maternal death notification rate in facilities is still below 20 per cent. Survey data indicate that the notification rate at community level is extremely low. Overall, the notification rate in 2015 was lower than in 2014, since many countries as of April 2016 did not yet have data on the number of 2015 cases. This highlights the need for more timely health information system data.

Figure 4.6: Range of notification rates in 32 MHTF-supported countries



In 2015, most countries implemented a maternal death surveillance and response system, but the level and coverage remained limited. Implementation progress should be monitored systematically. It is essential to share experiences between countries and identify success factors as well as barriers. The MHTF will encourage joint collaboration with local and international partners to increase notification and review.

Based on 2015 data, the MHTF has drawn maternal death surveillance and response system profiles for each MHTF-supported country. They provide a visual tool that is extremely useful in analysing national development of these systems.

Conclusion

Maternal death surveillance and response systems can dramatically improve maternal and newborn health, and a programme framework is complete in most MHTF-supported countries. However plans are often elaborated without cost estimates or budgets, and the MHTF will do more to advocate for these moving forward. In addition, early in the implementation phase, different countries are at varying stages of development of maternal death surveillance and response system. Common weaknesses remain in the capacity to register maternal deaths at the community level, to conduct good quality maternal death reviews and provide information on responses.

Asha, a young fistula survivor from Blue Nile State in Sudan, was successfully treated and gave birth to a healthy child.

© Mutwakil Mahmoud, UNFPA. Photo submitted by Yousra Abdelgabbar for MHTF Annual Report 2015 photo contest.



5

THE CAMPAIGN TO END FISTULA

HIGHLIGHTS

The MHTF supports countries where obstetric fistula persists to prevent and treat cases, and assists fistula survivors to successfully rebuild their lives. Evidence-based interventions and policies and technical guidance helped achieve high-impact results in 2015:

- Over 13,000 fistula repair surgeries were supported, 3,000 more than in 2014; the total number assisted by UNFPA from 2003 to 2015 is over 70,000.
- In 2012, UNFPA, in partnership with expert fistula surgeons, designed kits with all the necessary instruments and medical supplies for performing surgical repairs. In 2015, the MHTF supported the procurement of 568 kits for use at health facilities in 17 countries.
- The majority of MHTF-assisted countries are supporting social reintegration and the acquisition of income-generating skills critical for fistula survivors to provide for themselves and their families, and rebuild their sense of dignity and agency.
- UNFPA advocates for fistula-affected countries to develop costed, time-bound national strategies and action plans for eliminating the condition. By the end of 2015, 15 MHTF-supported countries had national strategies in place. Nine had costed operational plans.
- UNFPA helps countries in establishing and successfully operating national task forces for eliminating fistula. In 2015, 28 MHTF-assisted countries had these task forces.



Nasima Nizamuddin learned farming techniques at the Fistula Patients Training and Rehabilitation Centre in Dhaka, Bangladesh. “I feel that I can improve my life when I leave here,” she said.

© Nicolas Axelrod/Room for UNFPA.

Introduction

A Fistula Survivor’s Story: Life-Changing Treatment and Skills Training in Bangladesh

Obstetric fistula can occur when a woman or girl suffers from prolonged obstructed labour without timely access to emergency obstetric care, typically a C-section. The sustained pressure of the baby’s head on the mother’s pelvic bone damages her soft tissues, creating a hole – or fistula – between the vagina and bladder, rectum or both. In most cases, the baby is stillborn or dies within the first week of life, and the woman suffers a traumatic injury that renders her incontinent. Women are left with the constant odour of leaking urine and/or feces, and are often abandoned by their husbands and families. Their communities may stigmatize them, view them as “unclean,” and deny them access to employment or social gatherings.

These women include Nasima Nizamuddin from southern Bangladesh. Ms. Nizamuddin, 20, developed fistula due to complications during the birth of her son, Nayem. Her husband left her soon after the birth and the realization that she was incontinent.

Ms. Nizamuddin, however, was determined to change her situation. After receiving surgery that successfully repaired the fistula, she sought help at the Fistula Patients Training and Rehabilitation Centre in Dhaka, which provides fistula

survivors with psychosocial counseling and training in income-generating skills. The centre is supervised by the Government of Bangladesh and operated by the Bangladesh Women’s Health Coalition, and receives funding and technical support from the MHTF. It is the only centre of its kind in Bangladesh.

Ms. Nizamuddin chose to learn advanced agricultural techniques, such as animal rearing and organic farming. “I will be able to utilize the land I have and earn a lot of money, which I can use to help my family...I feel that I can improve my life when I leave here because of the skills I have learned,” she said.¹⁴

The Campaign to End Fistula at a Glance

The persistence of obstetric fistula – primarily among the poorest, most vulnerable and underserved women and girls worldwide – reflects severe inequity, and inadequate access to quality sexual and reproductive health services, including family planning, skilled birth attendance and referral to emergency obstetric and newborn care when needed. The MHTF makes it possible for UNFPA to lead and coordinate the global Campaign to End Fistula, an initiative of more than 90 global partners operating in over 50 countries across Africa, Asia, the Arab States and Latin America, with the goal of making obstetric fistula as rare in developing countries as it is in the industrialized world. The campaign was launched in 2003 to raise awareness and accelerate action to eliminate this severely neglected health and human rights tragedy. It focuses on three key interventions: prevention, treatment, and social reintegration and follow-up.

Country Highlights

Prevention

Obstetric fistula is almost entirely preventable when women have access to quality health services before, during and after pregnancy and delivery. While fistula has been all but eradicated in the industrialized world, it persists in developing countries. More than 2 million women and girls currently live with fistula, and 50,000 to 100,000 new cases occur each year.¹⁵ The persistence of fistula illustrates the failure of health systems and society as a whole to adequately care for the poorest and most marginalized women and girls.

¹⁴ This story was adapted from the UNFPA.org article, “Obstetric fistula: The road to recovery - and respect.” See: www.unfpa.org/news/obstetric-fistula-road-recovery-%E2%80%93-and-respect

¹⁵ Source: www.who.int/features/factfiles/obstetric_fistula/en/

To prevent maternal deaths and morbidity, including fistula, women and girls must have access to:

- Skilled, accessible and culturally appropriate care, including midwifery care, before, during and after pregnancy and delivery;
- High-quality, timely emergency obstetric care for those who develop complications; and
- Access to contraceptives to prevent unwanted pregnancies.

Through the MHTF, UNFPA and the Campaign to End Fistula are strengthening prevention by educating women, families and communities on the importance of delivering with a skilled birth attendant. Sensitizing community leaders and health workers, including midwives, on the risk of developing fistula and its causes is a key component of connecting women to skilled care during pregnancy and delivery.

UNFPA partners with local organizations and major national stakeholders to increase knowledge on prevention among leaders, health workers and community members. In 2015 in Nigeria, for example, UNFPA partnered with the Nigerian Ministry of Health and the civil society organization Fistula Foundation Nigeria to conduct advocacy visits across the country. These entailed meeting with government officials and traditional and religious leaders to familiarize them on the causes of fistula, and identify what resources are still needed to prevent and treat it. As a result, prominent leaders renewed commitments to eradicating fistula in their regions, and supported the provision of meals for women and girls with fistula during surgical treatment and recovery.

Identifying All Women and Girls with Fistula

As obstetric fistula largely affects poorer, marginalized women and girls, often living in remote areas, it can be a challenge to identify them, either in health facilities or communities, and then to connect them to treatment. In 2015, UNFPA in Ethiopia supported the training of 240 health extension workers and 129 nurses, midwives and doctors in fistula case identification to strengthen referrals to surgical treatment. Other assistance helped the Ghana Health Services to develop a good practice document on fistula case identification and referral. It catalogues existing practices

that have yielded promising results and will inform the establishment of a national fistula identification mechanism.

In the Democratic Republic of the Congo, UNFPA partners with local public, private and civil society entities to raise awareness on fistula and connect women to treatment. Fistula survivors who have undergone treatment help identify other women with fistula in their communities, and assist them to seek medical care. Media and community outreach campaigns spread prevention and treatment messages, and in 2015 reached an estimated 100,000 people in one province.

Removing Barriers to Treatment

In most cases, fistula can be surgically repaired by a highly skilled fistula surgeon. The average cost of treatment – including surgery, post-operative care and rehabilitation – is around US \$400 per patient. Most women and girls currently living with fistula, or who will develop fistula during their lifetimes, however, will die without receiving treatment.

Through the MHTF, UNFPA directly supports more than half of all fistula surgical repairs performed each year throughout dozens of countries in Africa, Asia and the Arab States. In 2015, UNFPA assisted more than 13,000 fistula surgical repairs globally, up from approximately 10,000 in 2014. A combination of funding for fistula repairs, technical support and guidance, and close collaboration with ministries of health and other partners can strategically increase efforts to prevent and treat fistula.

Madagascar saw an increase in fistula repairs supported by UNFPA from 513 in 2014 to 829 in 2015. The increase stems from intensified focus on routine facility-based surgeries (as opposed to surgeries performed during short-term campaigns), influenced in part by stronger partnerships with local non-governmental organizations (NGOs) and the World Food Programme. These partnerships ensured transportation to and from facilities, and the provision of meals and counseling during recovery. Health facilities and local surgeons were identified by the national fistula task force, of which UNFPA is a member, and supported in strengthening their capacity and leadership in performing fistula surgical repairs. With support from the MHTF, UNFPA plans to build on these successes in 2016, and to bolster social reintegration and training on income-generating activities for fistula survivors.

Training of Surgeons and Health Providers

Tragically, many low- and lower-middle-income countries have a shortage of surgeons and other trained medical staff compared to the need for services. Health workers tend to be unevenly distributed and found mostly in urban areas. In 2015, a Lancet Commission on global surgery stated that worldwide, “5 billion people do not have access to safe, affordable surgical and anesthesia care when needed. Access is worst in low-income and lower-middle-income countries, where nine out of ten people cannot access basic surgical care.”¹⁶ As a result, health as a basic human right is not being fully realized by the majority of people in these settings.

There are too few trained, expert surgeons skilled at performing quality fistula surgical repair, compared to the estimated numbers of women and girls in need. At global, regional and national levels, UNFPA works with several partner organizations, such as EngenderHealth/Fistula

¹⁶ Source: [www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(15\)60160-X.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)60160-X.pdf)

Care Plus, Fistula Foundation, Freedom From Fistula Foundation, the International Society of Obstetric Fistula Surgeons, the International Federation of Gynecology and Obstetrics, and Operation Fistula to promote high-quality training in fistula surgical repair. At the national level, the MHTF endorses the training of surgeons in a standardized curriculum for fistula repair developed by the International Federation of Gynecology and Obstetrics, the International Society of Obstetric Fistula Surgeons, UNFPA, EngenderHealth, and the Royal College of Obstetricians and Gynecologists.

In 2015, UNFPA in Liberia supported the integration of the fistula surgical training protocol and guidelines into the new postgraduate program for medical doctors. Going forward, medical students opting for specialization in obstetrics and gynecology will be required to undertake comprehensive fistula repair training prior to completion of their studies. This strategy will help ensure there are enough surgeons skilled in fistula repair.

South-South collaboration

Throughout 2015, the MHTF continued to facilitate South-South collaboration, training and knowledge sharing to strengthen capacities for fistula treatment and programming. For example, the MHTF supported the visit to Madagascar of International Federation of Gynecology and Obstetrics fistula surgeon Professor Serigne Magueye Gueye, of Cheikh Anta Diop University in Dakar, Senegal. At the University of Antananarivo Faculty of Medicine, members of the surgical team learned about the repair of obstetric fistula.

Provision of Supplies to Hospitals

Too often, surgeons and health providers in developing countries struggle with poor working conditions and limited supplies. Since 2012, UNFPA has made available two types of fistula repair kits with all the necessary items for the surgical repair of fistula. MHTF funding ensures these kits can be procured and distributed where needed, and 34 UNFPA country offices ordered them between 2012 and 2015 to distribute to hospitals and health facilities. In 2015 alone, 17 UNFPA country offices ordered a total of 286 Fistula Kit 1 kits and 282 Fistula Kit 2 kits.

UNFPA's fistula repair kits

UNFPA's two fistula repair kits were designed in 2012 in collaboration with expert fistula surgeons from the International Society of Obstetric Fistula Surgeons. Fistula Kit 1 includes all necessary medical instruments to perform one fistula repair, and the materials can then be sterilized and reused. Fistula Kit 2 contains supplementary medical supplies to provide 20 repairs and postoperative care. Both kits are available through UNFPA's reproductive health commodities procurement website (myaccessrh.org).

Social Reintegration and Rehabilitation

While surgical treatment to repair fistula is critical to ensure affected women and girls can rebuild their lives, it is not all that these women need or are entitled to receive. Fully supporting the health and well-being of women with fistula also requires a focus on social reintegration, so they are able to provide for themselves and their families. Follow-up over time helps ensure that if a woman becomes pregnant again, she receives the services she needs for the survival and health of herself and her baby.

In 2015, the majority of MHTF-supported countries trained fistula survivors in income-generating activities, and provided materials, such as sewing machines, to use new skills to earn a living. Assistance in the Democratic Republic of the Congo, Ghana, Guinea and Sierra Leone backed training on other valuable skills, beyond vocational activities, such as literacy and business development, and provided psychosocial counseling.

their broader national health strategies. Ghana and Zambia undertook studies in 2015 to define their fistula burden and provide evidence that will inform new national strategies.

National Fistula Task Forces

The MHTF has long emphasized that each country affected by fistula should have in place a national task force, led by the Ministry of Health in collaboration with UNFPA and all key fistula stakeholders, to support the development, implementation and monitoring of a national strategy and action plan to end fistula. In addition to MHTF focus countries, UNFPA in total supports over 50 fistula-affected countries in establishing and successfully operating such task forces. In 2015, 28 MHTF-supported countries had fistula task forces, including Somalia, which introduced them in all three zones (Somalia, Somaliland and Puntland).

Ethiopia becomes the first country to plan to eliminate fistula by 2020

In 2015, Ethiopia finalized an ambitious strategic plan for eliminating obstetric fistula by 2020. The plan, the first of its kind worldwide, was developed by the Federal Ministry of Health in collaboration with UNFPA and other partners. The strategy states that in Ethiopia, "The combined factors of low met need for [emergency obstetric and newborn care], high unmet need for family planning, and high early marriage and teenage pregnancy increases the risk of developing [obstetric fistula]."

Acknowledging that elimination of obstetric fistula requires prevention of new cases and repair of existing cases, the strategy sets comprehensive goals and targets that include improving community knowledge of fistula, reducing the unmet need for family planning to 10 per cent, increasing skilled attendance at birth to 90 per cent, raising coverage of basic and comprehensive emergency obstetric and newborn care services to 100 per cent, and increasing identification, referral and treatment of fistula cases to 100 per cent.

National Strategies for Eliminating Fistula

UNFPA and the Campaign to End Fistula promote national leadership and ownership in the push to end obstetric fistula by advocating for and supporting costed, time-bound national strategies and action plans linked to national health plans. By the end of 2015, 15 MHTF-supported countries had national strategies for eliminating fistula in place.¹⁷ Nine were also using costed operational plans. Several countries that do not currently have standalone national fistula strategies, such as Liberia and Nepal, have included fistula in

Global Highlights

Strengthening Identification and Tracking of Fistula Cases

UNFPA and the Campaign to End Fistula are leading global efforts to increase identification of fistula cases. In collaboration with WHO, UNFPA in 2015 began a key strategic initiative to make fistula a nationally notifiable condition. The overall goal is to ensure that all women and girls with obstetric fistula are identified, reached and treated. By systematically identifying, registering and tracking each woman and girl who has or had an obstetric

¹⁷ Annex 4 lists these countries.



Ms. Noor Jahan, a fistula survivor from Afghanistan, suffered for nearly 50 years because she was not aware that treatment was available.
©Andrea Bruce/NOOR

Regional awareness-raising brings attention to fistula in Asia

To spark support for ending fistula in Asia, in early 2015, UNFPA and the photo agency NOOR released a short documentary film titled “Suffering in Silence: Obstetric Fistula in Asia.” The film profiles four fistula survivors in Afghanistan, Nepal and Pakistan, as well as surgeons and providers in these countries. Ms. Noor Jahan of Afghanistan, for example, told about how she had suffered with fistula for nearly 50 years before she received treatment. The online version of The Guardian picked up the documentary and published an article about fistula in Nepal.

fistula, enormous strides can be made in improving their well-being and increasing the chances of their babies’ survival in subsequent pregnancies. Strengthening overall data on obstetric fistula will be a critical step forward in the era of the 2030 Agenda, with its strong emphasis on monitoring change.

Capacity-Building for Fistula Surgical Repair

In 2015, the MHTF helped convene surgeons from the International Society of Obstetric Fistula Surgeons in workshops on “Challenges in Management of the Complex

Obstetric Fistula” at both the annual meeting of the International Urogynecological Association and the 21st International Federation of Gynecology and Obstetrics World Congress. The workshops were intended for surgeons who regularly perform obstetric fistula repairs, and helped them better understand and address some of the more complex issues they face. Teachings will be shared in similar settings going forward.

Public-Private Partnerships

Among the Fistula Kit 2 kits ordered in 2015, primarily with MHTF funding, 153 contained Ethicon sutures donated by Johnson & Johnson. UNFPA negotiations under this public-private partnership reduced the cost by 39 per cent, enough to supply 500 kits per year over three years. This donation will help facilitate up to 10,000 surgeries per year.

Advocacy and Awareness-Raising

Advocacy and awareness-raising mobilizes governments and leaders to pledge to end fistula, sensitizes communities on the causes, and connects women and girls to support and treatment. A key advocacy and awareness-raising tool of the MHTF, the Campaign to End Fistula and their partners is the International Day to End Obstetric Fistula. It began in 2013, and is observed annually in fistula-affected countries as well as globally and regionally to strengthen commitment to eliminating fistula. Countries use the day to increase government leadership, ownership and buy in; to sensitize the public; and to prevent, identify and treat cases of fistula.

The International Day to End Obstetric Fistula was observed in 2015 with a side event during the World Health Assembly in Geneva. The event, hosted by UNFPA and the Permanent Missions of Ethiopia, Iceland and Liberia to the United Nations in Geneva, was titled “Going from global to local – National leadership and strategies toward ending fistula.” Distinguished panellists participated, generating enthusiasm to do more to end obstetric fistula. The Government of Iceland subsequently increased funding to UNFPA for fistula.

2015 saw increased advocacy around fistula in the United States. UNFPA, the Campaign to End Fistula, EngenderHealth, Fistula Care Plus, USAID, and Johnson & Johnson participated in a panel event at the Wilson International Center for Scholars in Washington, DC, titled “Restoring Hope and Dignity: New Developments and Best Practices in Addressing Maternal Morbidities.” United States Congresswoman Carolyn Maloney spoke at this event, which highlighted obstetric fistula and pelvic organ prolapse. The event preceded the introduction of a bill to Congress, the “Obstetric Fistula Prevention, Treatment, Hope, and Dignity Restoration Act of 2015.” If passed, the bill will authorize the

President of the United States to provide assistance for the prevention and treatment of fistula.

In July 2015, UNFPA was successful in advocating for the inclusion of obstetric fistula in the General Comment on women with disabilities drafted by the Office of the United Nations High Commissioner for Human Rights. UNFPA made the case that obstetric fistula is a human rights issue, and advocates for it to be classified as a disability according to the definition in the Convention on the Rights of Persons with Disabilities. Identifying obstetric fistula as a disability would require governments to ensure universal access to sexual and reproductive health and rights to prevent fistula; to treat, rehabilitate and care for affected women and girls; to eliminate the stigma and discrimination fistula survivors face; and to ensure their social inclusion and active participation.

Conclusion

UNFPA has directly supported over 70,000 fistula repair surgeries from the launch of the Campaign to End Fistula in 2003 to 2015 – more than any other organization in the world. Over 13,000 surgeries took place in 2015 alone, 3,000 more than in 2014. UNFPA is able to ensure access to these life-changing surgical repairs in large part due to MHTF funding.

The catalytic nature of MHTF funding and activities strengthens fistula prevention and treatment actions, and extends crucial support and follow-up to fistula survivors. The MHTF also makes it possible for UNFPA and the Campaign to End Fistula to advocate for heightened awareness and support for eradicating fistula at the global, regional and national levels; provide technical leadership and guidance; build national and sub-national capacities to scale up cost-effective prevention, treatment and reintegration; convene and coordinate a growing coalition of key stakeholders through the Campaign to End Fistula and the International Obstetric Fistula Working Group (UNFPA is the Secretariat for the latter); and support evidence-based policy-making and programming.

The fight to end fistula is far from over. In the era of the SDGs and the 2030 Agenda, UNFPA, as the main UN agency working to eliminate fistula and leader of the global Campaign to End Fistula, is strategically positioned to use the MHTF to strengthen financial and technical support that accelerates progress by achieving effective and lasting results.



In the rural Eastern Province of Zambia, UNFPA provides young girls and adolescent mothers with health, social and economic assets through “safe spaces,” contributing to better sexual and reproductive health.

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6 | FIRST-TIME YOUNG MOTHERS

HIGHLIGHTS

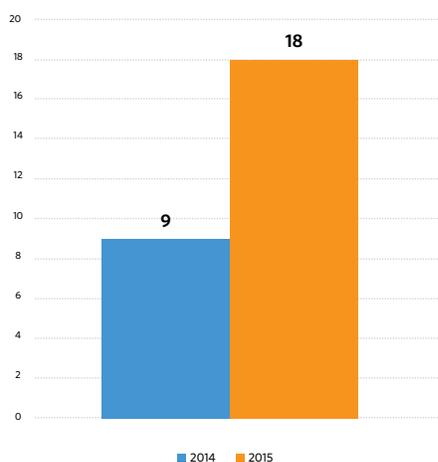
- In 2015, 9 MHTF-supported countries prioritized first-time young mothers in their National, Reproductive, Maternal, Newborn, Child and Adolescent Health Plans and Strategies, 18 countries in total have taken this step since 2014.
- 8 countries supported by the MHTF have started mobilizing to implement at least one innovative, scalable approach to improving maternal health services use by first-time young mothers in 2015.

In 2014, support for first-time young mothers was introduced as a fifth focus area for the MHTF. This opened a unique opportunity to improve sexual and reproductive health and life prospects early in life, and to provide services in an integrated manner. About 70,000 adolescents in developing countries die each year from complications during pregnancy and childbirth.¹⁷ Quality antenatal care is important to identify and mitigate risk factors in pregnancy and to encourage women to have a skilled attendant at birth. Many pregnant women in developing countries start antenatal care late, however, particularly if they are adolescents.

Adolescent mothers face serious risks, including obstetric fistula. Stillbirths and death in the first week of life are 50 per cent higher among babies born to mothers younger than 20 than among babies born to mothers who are 20 to 29 years old.¹⁸ A variety of interventions are needed to reduce mortality and morbidity, prevent additional unwanted/unplanned pregnancies and sexually transmitted infections, increase the spacing of pregnancies, improve parenting skills, elevate partner and family support, facilitate early intervention for post-partum depression, stop gender-based violence, strengthen autonomy and the sense of control, and encourage continuation of school.

In 2015, nine more MHTF-supported countries decided to prioritize first-time young mothers in national reproductive, maternal, newborn, child and adolescent health plans; in total, 18 countries have now taken this step (Figure 6.1).

Figure 6.1: Number of MHTF-supported countries where first-time young mothers are a priority in national health plans

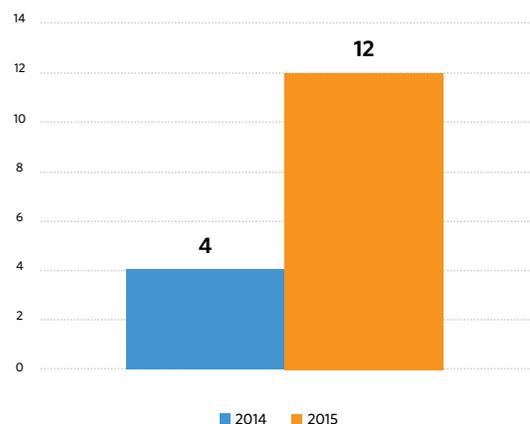


¹⁷ WHO, UNICEF and UNFPA. 2004. Maternal Mortality in 2000. Geneva: WHO. WHO Global Burden of Disease estimates.

¹⁸ Source: www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/, accessed on 24 June 2016.

Eight more countries in 2015 declared they would implement at least one innovative, scalable approach to improving maternal health service use by first-time young mothers (Figure 6.2).

Figure 6.2: Number of MHTF-supported countries taking at least one action to improve the maternal health of first-time young mothers.



Country Highlights

Liberia

The first year of the programme in Liberia explored further identification of innovative and scalable approaches to reach first-time young mothers. Liberia rolled out a pioneering programme despite being in the midst of the national Ebola crisis. In 2013, 31.3 per cent of teenage girls (2,080) had begun childbearing, among which 5.5 per cent were pregnant with their first child and 28.5 per cent had a live birth (Demographic and Health Survey, 2013).

The project reached out to 400 pregnant first-time young mothers, with three main objectives:

1. Improve use of maternal health services among first-time young mothers in targeted communities, including antenatal care, skilled birth attendance and post-partum care with contraceptive services;
2. Strengthen the capacity of health-care providers and community health workers to provide services to interact with first-time young mothers, and set up a follow-up mechanism with other services; and
3. Increase access to post-partum family planning services for first-time young mothers.

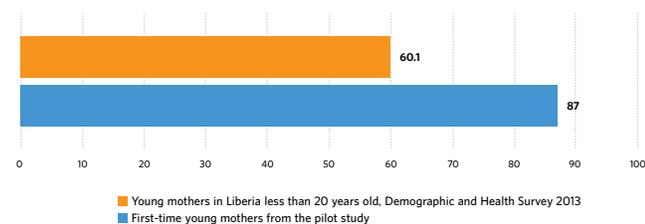


Picture of Esther with her first baby, resident of Gando (Togo). 16 years old, with complications at the time of delivery, she gave birth thanks to the timely use of manual extraction made available by UNFPA at the Gando Medical center. © Afi Dovi Gbodui, UNFPA. Photo submitted for MHTF Annual Report 2015 photo contest.

Almost all girls (97 per cent) engaged in the project had one antenatal check-up, while 57 per cent completed all four antenatal check-ups.

Among the girls, 44.5 per cent gave birth (178), and 87 per cent (156) of them delivered at a health facility (Figure 6.3). This is higher than the 60.1 per cent average for facility births in Liberia among young women less than 20 years old (Demographic and Health Survey, 2013).

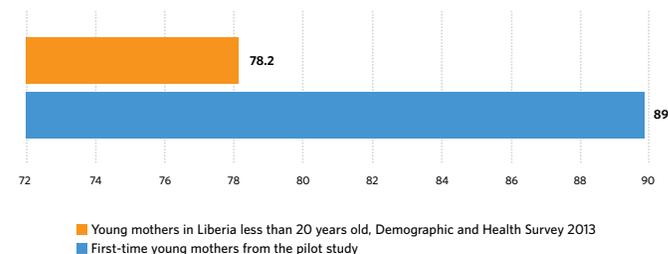
Figure 6.3: Percentage of first-time young mothers delivering in a health facility in Liberia



No maternal deaths were reported. There were seven newborn deaths; five occurred in the community and two at the health facility.

Postnatal care was very well received by the first-time young mothers; 160 (89 per cent) came for these visits (Figure 6.4). Yet only 38 (21 per cent) accepted family planning. The desired need for post-partum family planning to prevent unwanted pregnancies or space pregnancies was not high. More needs to be done to improve acceptance of existing family planning services, and to make family planning an important component of antenatal care for first-time young mothers.

Figure 6.4: Percentage of women who received a check-up beyond 41 days after delivery



Several challenges identified in Liberia should be taken into account for scaling up the programme. These include the



Benin © Ollivier Girard, UNFPA

high cost of health-care services, cultural barriers to accessing services, constraints on follow-up household visits due to limited information on specific addresses, and gaps in the provision of friendly and respectful care.

The Ebola outbreak hampered some progress in 2015. For example, clear training guidelines still need to be developed for health-care workers to deliver high-quality care. The involvement of community health workers in follow-up visits will be important in helping young women access services as well as in building their confidence.

As a baseline study was conducted and a monitoring and evaluation framework is in place, UNFPA will draw upon experiences from this programme to design evidence-based programmes in nine additional countries. It will suggest scaling up the programme in more districts of Liberia and ultimately at the national level, since commitment and national leadership are in place along with resources and a resource mobilization plan.

Madagascar

In Madagascar, maternal and newborn health status remains poor in a context of prevalent poverty. According to the national MDG survey in 2013, 92 per cent of people live on

less than US \$2 per day per person. The maternal mortality ratio remains high at 478 maternal deaths per 100,000 live births with no reduction for the last two decades, and the newborn mortality rate has risen from 24 per 1,000 in 1998 to 26 per 1,000 in 2013. Every day, 10 women die from pregnancy-related issues. One woman in three who dies is an adolescent girl between 15 and 19 years old.

In view of the poor access of women, adolescent girls and newborns to quality health services, the MHTF in 2015 set up an initiative addressing the needs of first-time young mothers, especially those under 24 years old, and adolescent girls. UNFPA has been partnering with Marie Stopes Madagascar to implement this initiative in remote areas of the Atsimo Andrefana Region in the south of the country.

The programme aims to increase the access of first-time young mothers to sexual and reproductive health information and free antenatal care, skilled birth attendance and family planning to prevent or space pregnancies. Twenty trained peer educators have been working closely with five selected franchised blue-star health facilities of Marie Stopes Madagascar. They sensitize first-time young mothers on the availability and benefits of antenatal care, skilled birth delivery at health facilities and post-

partum family planning. First-time young mothers also receive vouchers that enable them to access free antenatal care, skilled birth attendance and/or post-partum family planning services at Marie Stopes facilities.

Within five months of implementation, more than 4,008 young mothers were sensitized; 887 young mothers (22 per cent) had sought antenatal care and/or birth delivery at health facilities; and 1,543 mothers (38 per cent) received post-partum family planning. In 2016, a special focus is being put on further increasing demand for health services and post-partum family planning for first-time young mothers, and closely monitoring key result indicators.

Benin

The last demographic study of Benin showed that 17 per cent of adolescent girls between 15 and 19 years old are pregnant for the first time or already have a child. This share rises to 37.4 per cent by age 19. Moreover, 43 per cent of women aged 20 to 49 had their first delivery as an adolescent.¹⁹ The Government of Benin has committed to preventing adolescent pregnancies and increasing quality care for first-time young mothers.

In 2015, with the support of the MHTF, Benin initiated the elaboration of a multisectoral national strategy to prevent and tackle early pregnancies, and to promote quality maternal health-care services for first-time young mothers. Based on terms of reference validated by the Ministry of Health, and with UNFPA assistance, the process will move forward in 2016.

Conclusion

Strengthening national capacity to reach and serve first-time young mothers is one of the important outcomes of MHTF support. UNFPA through the MHTF is supporting countries to ensure that first-time young mothers are a priority population in national reproductive, maternal, newborn, child and adolescent health plans, and is targeting 10 countries in piloting at least one innovative, scalable approach to improving maternal health service use by first-time young mothers.²⁰

¹⁹ Institut National de la Statistique et de l'Analyse Économique and ICF International. 2013. Enquête Démographique et de Santé du Bénin 2011-2012. Calverton, Maryland: Institut National de la Statistique et de l'Analyse Économique and ICF International.

²⁰ The 10 countries are Bangladesh, Benin, Burundi, Democratic Republic of the Congo, Kenya, Liberia, Madagascar, Mozambique, Rwanda and Zambia



A woman and her infant child at the International Centre for Diarrhoeal Disease Research in Dhaka, Bangladesh.
© Mark Garten, UN.

7 | RESOURCES AND MANAGEMENT

HIGHLIGHTS

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

In 2015, the Thematic Trust Fund for Maternal Health:

- Had an operating budget of US \$18.4 million;
- Achieved an implementation rate of 87 per cent;
- Allocated 81 per cent of its approved allocations (US \$12.5 million) for regional and country programmes in 38 countries excluding Yemen.

In 2015, the Thematic Fund for Obstetric Fistula:

- Had an operating budget of US \$610,000;
- Achieved an implementation rate of 72 per cent; and
- Allocated 100 per cent of its expenditures for regional and country programmes, primarily in sub-Saharan Africa.

In terms of MHTF expenditures in countries, the midwifery and obstetric fistula programme components accounted for the majority, at 38 per cent and 34 per cent, respectively, followed by emergency obstetric and newborn care at 18 per cent.

In 2015, UNFPA established the Non-Core Funds Management Unit in the Office of the Executive Director to improve synergies among thematic funds and increase harmony with UNFPA's regular or core resources.

The steady increase in donors contributing non-core funds to UNFPA, along with reductions in official development assistance from traditional donors and the launching of new financing mechanisms such as the Global Financing Facility, demanded more coordinated management of UNFPA's non-core funds. While the allocation of resources has been the responsibility of the managers of respective thematic funds, standardized allocation criteria and the stronger involvement of regional offices would increase synergies among funds and harmony with UNFPA's regular or core resources.

To respond to this challenge, UNFPA in 2015 established the Non-Core Funds Management Unit in the Office of the Executive Director. It helps ensure that, despite the increase and diversity of non-core funding, UNFPA continues to function seamlessly in the achievement of its strategic goals.

The work is carried out within a corporate governance framework that fosters harmonization, integration and transparency in decision-making processes, accountability across the management of non-core resources and standardization of practices.

New systems and tools have been developed by UNFPA's Technical Division and the Non-Core Funds Management Unit, and put in place to improve the management of non-core resources. The main changes relate to work-planning and resource allocation, and took effect in 2016. Key objectives are to transfer funds to country offices earlier in the year and allocate resources in accordance with pre-defined criteria based on country needs. The MHTF team agreed on criteria and weighting that will be evaluated and adjusted if necessary by mid-2016 (Table 7.1).

Table 7.1: MHTF Resource Allocation Criteria and Weighting

MHTF resource allocation criteria and weighting	Weight, percentage
Maternal mortality ratio	20
Skilled birth attendant met need	20
Emergency obstetric and newborn care availability	20
Expenditure rate	20
Maternal health programme monitoring (to what extent is information available at various levels in the country)	20
Total	100

In 2015, the MHTF continued to work in high maternal mortality countries in accordance with its programme agreement. Funds were allocated to activities in 38 countries and 2 regional offices, slightly less than in 2014 where 39 country offices and 3 regional offices received funds. Countries and regional offices that received funds in 2014 but not in 2015 were the UNFPA West and Central Africa Regional Office, Cambodia and Yemen. Senegal did not receive funds in 2014 but was allocated US \$154,000 in 2015 (see Table 7.4 for more details). The changes are connected to needs and the political situations in countries. The MHTF constantly assesses where and through which activities its resources can achieve the most significant impacts.

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

Thematic Trust Fund for Maternal Health

Contributions

As shown in Table 7.2, US \$14.8 million was received by the Thematic Trust Fund for Maternal Health in 2015, a 19 per cent decrease from 2014, when it received US \$18.3 million.

Table 7.2: Total donor contributions to the Thematic Trust Fund for Maternal Health in 2015

Donors	Recognized revenue* (US\$)	Collected revenue (US\$)*
Friends of UNFPA	74,206.00	3,179.00
Germany	822,368.42	1,124,859.39
Luxembourg	1,292,517.01	1,292,517.01
Sweden		11,835,720.20
TOTAL 2015	2,189,091	14,835,720

*Recognized revenue signifies new pledges in 2015, whereas collected revenue comprises the actual amounts transferred to UNFPA in 2015. For this report, the latter column is the most important. Recognized revenue is shown because it may appear in other financial statements for this programme.

Operating Budget

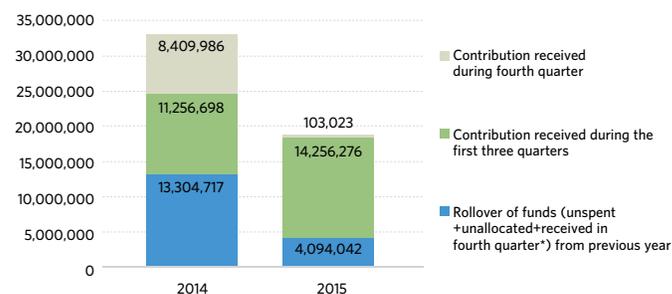
The operating budget for the Thematic Trust Fund for Maternal Health in 2015 encompassed the end-of-year balance for 2014 plus income received during the first three quarters of 2015. Income received during the fourth quarter will typically be carried over to the following year, since it normally cannot be programmed and expended within so few months. In accordance with the International Public Sector Accounting Standards, transactions are only recorded as expenses when the services or goods have actually been carried out or handed over to the implementing partner.

As Table 7.3 shows, US \$4 million was carried over from 2014 to 2015, mainly because contributions of US \$7.7 million were received in the fourth quarter of 2014 and only partly used then. The Thematic Trust Fund for Maternal Health received US \$14.3 million in donor contributions during the first three quarters of 2015. No donor contributions were received during the fourth quarter, when the only income was bank interest of US \$100,000. This brings the total budget for the Thematic Trust Fund for Maternal Health to US \$18.5 million in 2015, and the operating budget to US \$18.4 million (Figure 7.1).

Table 7.3: Budget for the Thematic Trust Fund for Maternal Health in 2015

Donors	Contributions (US\$)
Carry-over from 2014	4,094,042
Friends of UNFPA	3,179
Germany	1,124,859
Luxembourg	1,292,517
Sweden	11,835,720
Bank interest	103,023
TOTAL	2,189,091

Figure 7.1: Operating budget for maternal health in 2014 and 2015 (in US\$ millions)



Expenses

In 2015, expenditures for maternal health through the Thematic Trust Fund for Maternal Health totaled US \$13.4 million, compared to US \$16.8 million in 2014 and US \$17.3 million in 2013.

During 2015, spending by country and regional programmes accounted for 74 per cent of expenditures, whereas global activities accounted for 26 per cent. One-third of global expenses (US \$1.1 million) was disbursed via international NGOs. Out of total expenditures, 16 per cent or US \$2.2 million was distributed via NGOs.

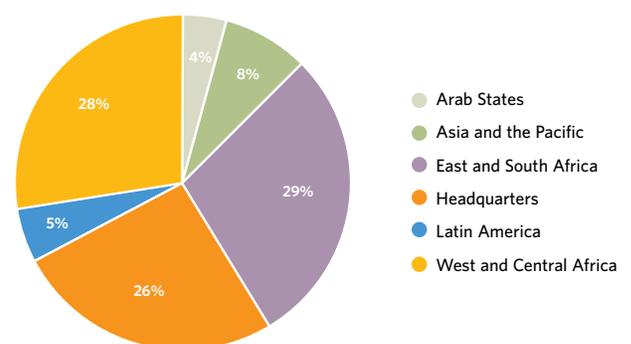
Table 7.4: Approved allocations, expenditures and financial implementation rates for maternal health in 2014 and 2015.

Regional office/country office/ global technical support/ partners	2014			2015		
	Approved allocations (US\$)	Expenditures (US\$)	Implementation rates (%)	Approved allocations (US\$)	Expenditures (US\$)	Implementation rates (%)
Sub-Saharan Africa						
East and Central Africa Regional Office/ Johannesburg	262,500	155,094	59	79,180	38,101.18	48%
West and Central Africa Regional Office/Dakar	210,000	28,903	14	-	(7)	0%
Benin	420,000	395,190	94	300,762	324,875	108%
Burkina Faso	500,000	399,268	80	308,000	401,408	130%
Burundi	385,000	397,055	103	296,450	279,224	94%
Cameroon	35,000	30,554	87	39,590	38,047	96%
Central African Republic	128,079	63,121	49	159,497	111,771	70%
Chad	960,000	820,773	85	739,038	670,403	91%
Congo	120,000	115,064	96	120,000	104,205	87%
Côte d'Ivoire	443,539	380,951	86	385,000	285,344	74%
Democratic Republic of the Congo	1,001,630	962,921	96	804,538	561,754	70%
Ethiopia	750,000	1,485,731	198	1,700,074	1,090,253	64%
Ghana	270,000	272,987	101	207,912	189,765	91%
Guinea	180,000	94,017	52	148,302	162,074	109%
Guinea-Bissau	140,000	100,187	72	3,282	68	2%
Kenya	215,000	191,250	89	165,604	125,627	76%
Liberia	210,000	185,725	88	177,098	132,332	75%
Madagascar	595,000	554,535	93	431,200	431,261	100%
Malawi	315,000	279,041	89	126,000	108,295	86%
Mali	120,000	56,164	47	92,400	56,293	61%
Mauritania	60,000	55,862	93	96,162	62,002	64%
Mozambique	140,000	134,497	96	107,800	100,961	94%
Niger	280,000	272,196	97	215,600	229,385	106%
Nigeria	300,000	281,886	94	372,497	261,850	70%
Rwanda	150,000	149,964	100	182,940	163,584	89%
Senegal		-12,764		154,000	141,546	92%
Sierra Leone	515,000	525,018	102	437,225	437,749	100%
South Sudan	612,500	610,441	100	494,340	460,164	93%
Togo	100,000	99,729	100	77,000	71,336	93%
Uganda	350,000	428,843	123	302,437	293,893	97%
Zambia	300,000	292,708	98	231,000	214,981	93%
Sub-Saharan Africa total	10,180,748	9,957,213	98	8,954,928	7,548,542	84%
Arab States						
Republic of Yemen	100,000	75,026	75	-	-	
Djibouti				-	(65)	0%
Somalia	300,000	306,372	102	275,390	271,508	99%
Sudan	425,000	369,950	87	327,250	301,240	92%
Arab States total	825,000	751,348.71	91	602,640	572,683	95%

Regional office/country office/ global technical support/ partners	2014			2015		
	Approved allocations (US\$)	Expenditures (US\$)	Implementation rates (%)	Approved allocations (US\$)	Expenditures (US\$)	Implementation rates (%)
Asia and the Pacific						
Afghanistan	438,800	398,911	91	335,000	330,956	99%
Bangladesh	120,000	119,985	100	119,840	116,905	98%
Cambodia	80,000	79,935	100			
Timor-Leste	156,000	136,472	87	77,000	86,592	112%
Lao People's Democratic Republic	282,587	267,492	95	282,801	280,947	99%
Nepal	100,000	95,480	95	100,045	94,213	94%
Pakistan	250,000	229,981	92	191,304	181,082	95%
Asia and the Pacific total	1,427,387	1,328,256	93	1,105,990	1,090,695	99%
Latin America and the Caribbean						
Latin America and the Caribbean Regional Office/Panama	87,500	74,691	85	87,500	87,499	100%
Sub-regional office/Kingston	0	3,534			1,010	0%
Haiti	950,599	935,246	98	654,500	632,156	97%
Latin America and the Caribbean total	1,038,099	1,013,470	98	742,000	720,665	97%
Global technical support						
Global technical support, including implementing partners	3,606,627	3,210,603	89	3,574,627	3,012,178	84%
Information and External Relations Division	282,800	278,290	98	116,058	72,024	62%
Media and Communications Branch	250,000	249,431	100	194,242	194,962	100%
Non-Core Funds Management Unit	0	0	0	200,071	198,354	99%
Global technical support total	4,139,427	3,738,323	90	4,084,998	3,477,519	85%
GRAND TOTAL	17,610,660	16,788,611	95	15,490,556	13,410,103	87%

East and South Africa accounted for most of the funds allocated to maternal health, with 29 per cent (US \$3.87 million) of the total. West and Central Africa came second at 28 per cent (US \$3.69 million). Global allocations constituted 26 per cent (US \$3.47 million), but approximately one-third of this share went to NGOs and other institutions for them to disburse. Asia and the Pacific accounted for 8 per cent (US \$1.09 million), Latin America and the Caribbean for 5 per cent (US \$720,000) and the Arab States for 4 per cent (US \$570,000). See Figure 7.2.

Figure 7.2: Share of expenditures for maternal health by region and globally in 2014 and 2015



2015 expenditures on maternal health of US \$13.4 million represented a financial implementation rate of 73 per cent against the total operational budget of US \$18.4 million. The amount transferred to 38 country offices, 2 regional offices and headquarters units was US \$15.5 million. As in previous years, part of the budget was kept to manage

unexpected issues faced by countries and regions, and variations in exchange rates. Against approved allocations, the implementation rate was 87 per cent in 2015. This compares to 95 per cent in 2014, where total approved allocations were US \$17.6 million and expenses were US \$16.8 million for 39 countries, 3 regional offices and headquarters units. The implementation rates for 2013, 2012 and 2011, respectively, were: 94 per cent, 91 per cent and 88 per cent.

Support to Country, Regional and Global Programmes

As highlighted in Table 7.4, the total allocation to country, regional and global programmes in 2015 was US \$15.5 million; corresponding expenses were US \$13.4 million. Corresponding figures for 2014 were US \$17.6 million and US \$16.8 million, respectively.

In 2015, US \$11.4 million went to regional and country programmes, and US \$4.1 million to global programmes and activities. The global amount includes US \$1.1 million distributed to international NGOs and institutions in support of their country interventions. The correct distribution between country and global programme allocations is thus US \$12.5 million (81 per cent) for country activities and US \$3 million (19 per cent) for global programmes.

In comparison, in 2014, US \$14.62 million (83 per cent) was allocated for regional and country programmes and US \$2.96 million (17 per cent) for global programmes.

Thematic Trust Fund for Obstetric Fistula

For the Thematic Trust Fund for Obstetric Fistula, the trend of less direct funding by donors continued in 2015, albeit largely at the same level of funding as in 2014. Funding for obstetric fistula activities continued to be increasingly channeled through the Thematic Trust Fund for Maternal Health.

Contributions

Table 7.5 shows that donor contributions (recognized and collected revenues) in 2015 reached US \$370,000. In 2014, collected revenue was US \$400,000.

Table 7.5: Total recognized and collected revenue for 2015

Donors	Recognized revenue* (US\$)	Collected revenue (US\$)*
Friends of UNFPA	13,647	13,647
Iceland	89,473	89,473
Luxembourg	238,095	238,095
Poland	29,053	29,053
TOTAL 2015	370,269	370,269

* Recognized revenue signifies new pledges in 2015. Collected revenue is the actual amount transferred to UNFPA.

Operating Budget

Table 7.6 shows that the operating budget for the Thematic Fund for Obstetric Fistula for 2015 was significantly larger than contributions received in 2015 because it includes carry-over funds from 2014. The 2015 contribution from Poland was not included, however, since it was received in the fourth quarter of 2015. It will therefore be spent for interventions in 2016.

Table 7.6: Operating budget for the Thematic Fund for Obstetric Fistula for 2015

Donors	Contributions (US\$)
Carry-over from 2014	237,809
Iceland	89,473
Luxembourg	238,095
Friends of UNFPA	13,647
Bank interest	3,460
TOTAL 2015	582,484

Figure 7.3 shows how the 2015 operating budget for the Thematic Fund for Obstetric Fistula compared to 2014. The downward trend is not an indication of failing support to fistula, but reflects the tendency for more funds to be channeled through the Thematic Trust Fund for Maternal Health.

Figure 7.3: Operating budgets for obstetric fistula in 2014 and 2015 (US\$ millions)

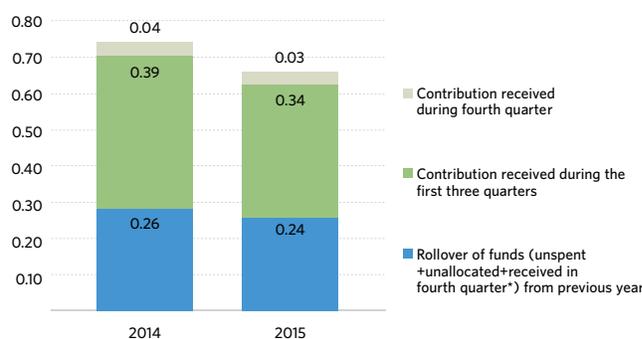
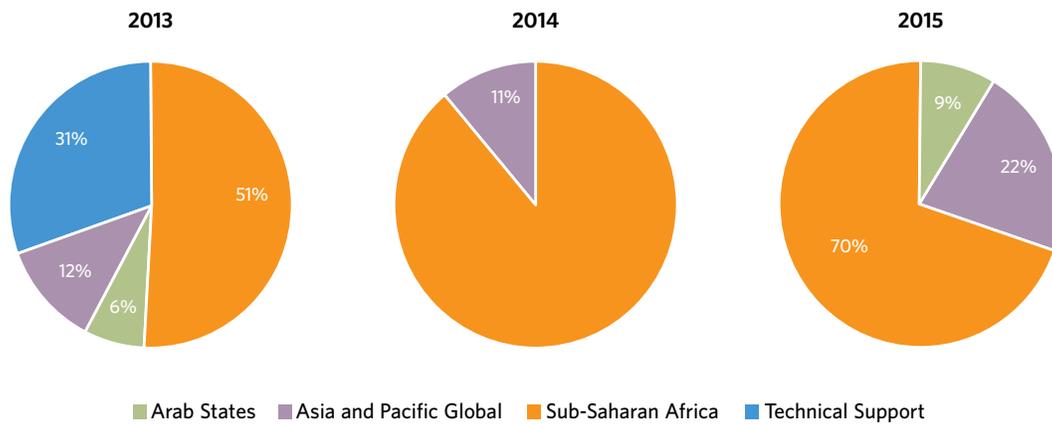


Figure 7.4: Shares of expenditures for obstetric fistula by region and globally in 2013, 2014 and 2015



Expenses

Expenses in 2015 from the Thematic Fund for Obstetric Fistula reached a total of US \$260,000, compared to US \$490,000 in 2014.

In light of limited resources, funds were only available for country programmes, including spending by international NGOs and institutions supporting programme activities

in countries mainly in sub-Saharan Africa. The share of expenditures among regions is shown in Figure 7.4.

Total expenditures of US \$260,000 represent a financial implementation rate of 42 per cent compared to the operational budget of US \$610,000. Based on total allocations of US \$370,000, the implementation rate was 72 per cent (Figure 7.5).

Figure 7.5: Operating budget, allocations and expenditures for obstetric fistula in 2013-2015 (US\$ millions)

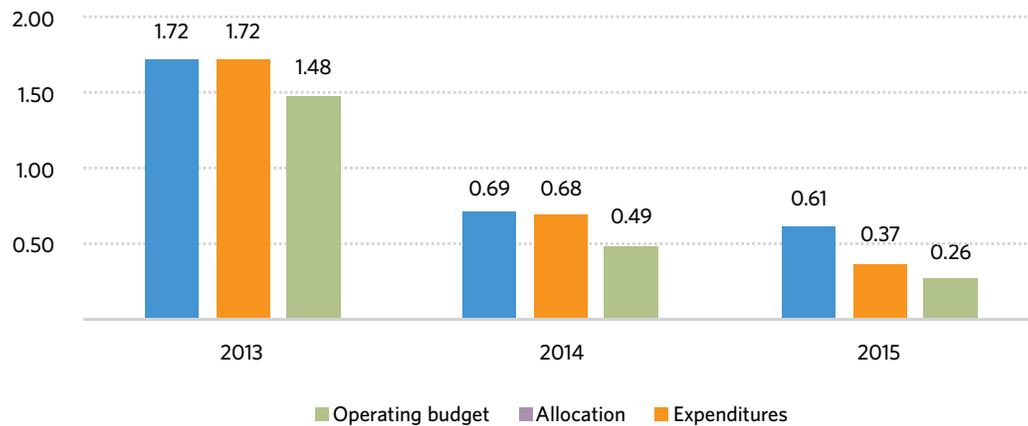


Table 7.7: Approved allocations, expenditures and financial implementation rates for obstetric fistula in 2014 and 2015

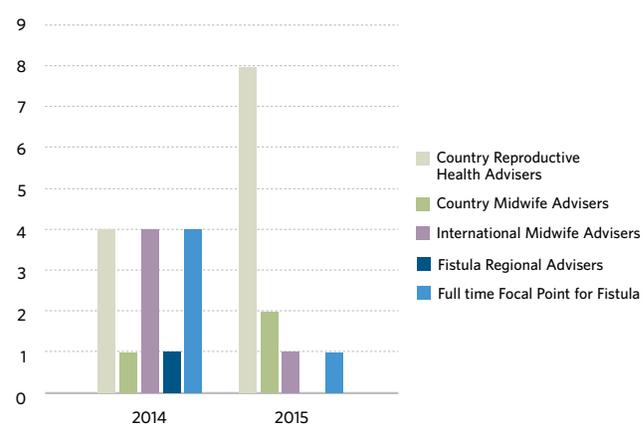
Regional office/country office/ global technical support/ partners	Approved allocations (US\$)	Expenditures (US\$)	Implementation rates (%)	Approved allocations (US\$)	Expenditures (US\$)	Implementation rates (%)
Sub-Saharan Africa						
Benin*		191			147	
Cameroon	65,000	43,808	67%	42,800	35,028	82%
Côte d'Ivoire	56,461	20,736	37%			
Democratic Republic of the Congo	48,370	26,687	55%			
Eritrea	50,000	48,000	96%			
Guinea*		(42)		29,892	19,934	67%
Guinea-Bissau*		27				
Kenya*		18				
Mauritania*	40,000	38,439	96%		(12,980)	
Nigeria	100,000	92,979	93%	27,503	26,704	97%
Senegal	200,000	135,096	68%		(8,363)	
Sierra Leone - Freetown				77,775	76,086	98%
South Sudan	57,500	32,790	57%			
Uganda - Kampala				47,563	47,413	100%
Sub-Saharan Africa total	617,331	438,729	71%	225,533	183,968	82%
Arab States						
Somalia		0		24,610	23,183	94%
Arab States total		0		24,610	23,183	94%
Asia and the Pacific						
Afghanistan	61,200	53,237	87	115,000	56,997	50%
Asia and the Pacific total	61,200	53,237	87%	115,000	56,997	50%
GRAND TOTAL	678,531	491,966	73%	365,143	264,148.17	72%

*Countries that carried over expenditures from 2014.

Support to Country Programmes

Allocations to country, regional and global programmes for obstetric fistula totaled US \$370,000 in 2015, compared to US \$680,000 in 2014 (Table 7.7). All allocations went to country activities in 2015. As a region, sub-Saharan Africa absorbed the largest share at 70 per cent (US \$180,000). The Asia and the Pacific region accounted for 22 per cent (US \$60,000), and the Arab States region for 9 per cent (US \$20,000).

Figure 7.6: Human Resources supported by the MHTF

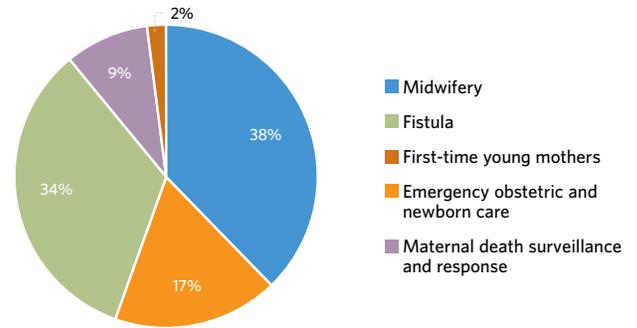


Source: MHTF report (2014) and COGNOS human resources report (2015)

Linking MHTF Results to Financing

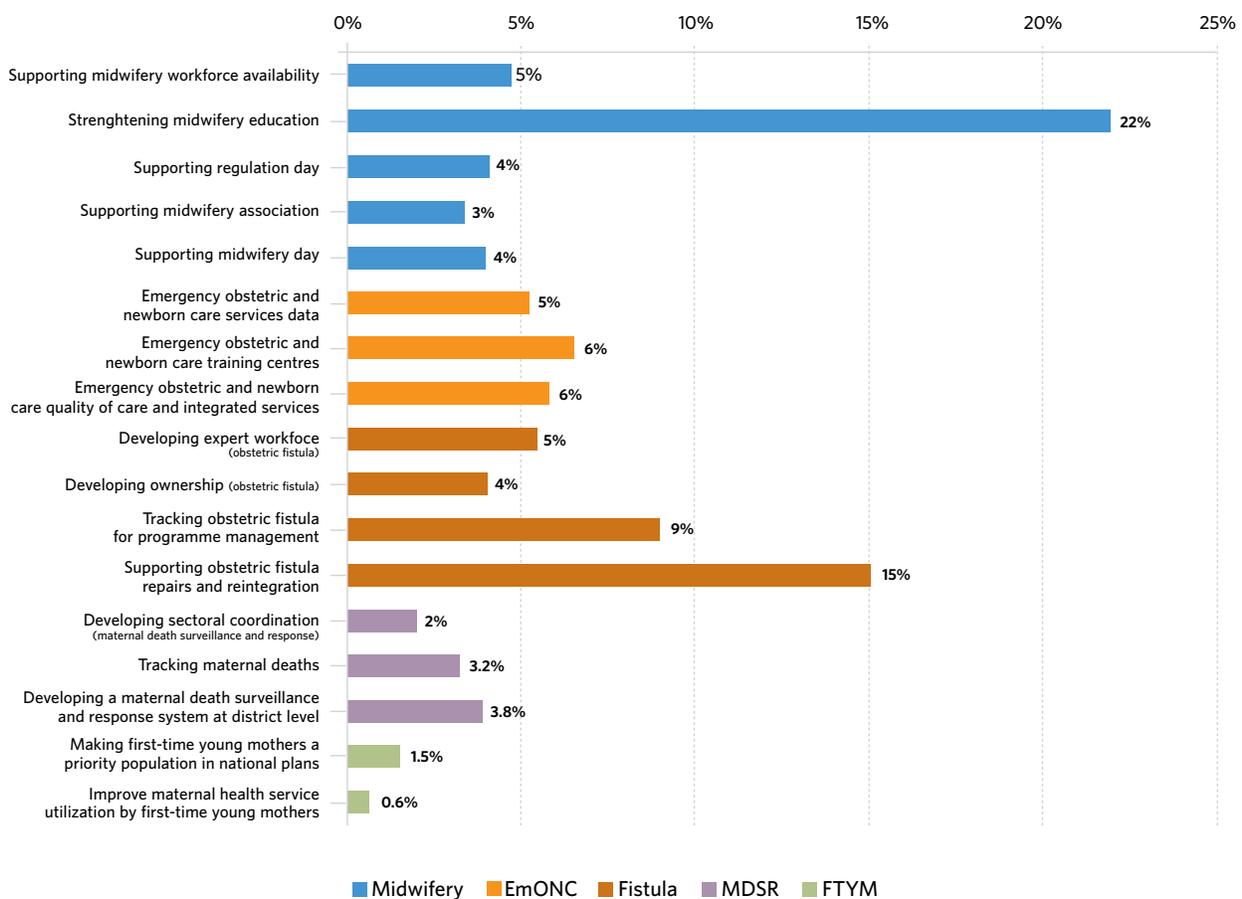
Figure 7.7 provides an estimate of how MHTF resources as a whole were spent by UNFPA country offices on programmatic outputs in 2015. The midwifery component took up the largest share at US \$4.3 million or 32 per cent of expenditures. With most funding for the fistula campaign now channeled through the Thematic Trust Fund for Maternal Health, the Campaign to End Fistula accounted for 24 per cent of MHTF expenses, totalling US \$3.3 million. Costs for emergency obstetric and newborn care activities amounted to US \$3.9 million or 29 per cent of expenditures. Coordination and technical assistance absorbed US \$1.4 million or 11 per cent. Work on maternal death surveillance and response systems (US \$400,000 or 3 per cent) and activities for first-time young mothers (US \$100,000 or 1 per cent) remained relatively small in terms of cost.

Figure 7.7: Distribution of resources by MHTF focus area*



A new Results Indicators Framework has allowed further breakdown of resources vis-à-vis activities (Figure 7.8). This will enable the MHTF in Phase II to link results closely to costs, making more analysis possible of the most cost-effective interventions, while keeping in mind that MHTF components are intrinsically linked.

Figure 7.8: Breakdown of expenses by intervention area*



* The breakdown includes country activities and staff expenditures related to MHTF intervention areas as defined in the MHTF result framework (representing US \$9 million). It does not include (a) approved activities that cover multiple maternal health areas, such as technical support on the development of a reproductive, maternal, newborn and child health national plan; (b) approved activities that are relevant for MHTF intervention areas but not directly linked to the generic results framework; and (c) coordination, management, monitoring and reporting costs. Data for the Central African Republic, Guinea Bissau and Mali are missing.



A midwife in Nepal counsels a newly married girl benefiting from one of the UNFPA-supported reproductive health camps organized after the devastating 2015 earthquake.
© Santosh Chhetri, UNFPA. Photo submitted for MHTF Annual Report 2015 photo contest.

8

OPPORTUNITIES AND WAY FORWARD

MHTF added Value

- The MHTF provides high-quality, responsive and targeted technical assistance to strengthen the capacities of countries to achieve improved maternal and newborn health outcomes.
- The MHTF supports strategic, cost-effective and evidence-based interventions proven to both strengthen health systems, and realize universal access to sexual and reproductive health and rights.
- The MHTF's assistance helps countries operationalize the 2030 Agenda and the Global Strategy for Women's, Children's and Adolescents' Health, including through key interventions that contribute to the survive, thrive and transformative actions included in the Every Woman, Every Child agenda.
- The MHTF supports countries to develop national maternal and newborn health policies and strategies within sexual and reproductive health frameworks to improve the availability of services and bolster national accountability mechanisms.
- The MHTF is able to leverage entry points, processes and critical partnerships, such as the H6, to scale up improvements in maternal and newborn health.
- The MHTF invests in a stronger evidence and state-of-the-art knowledge alongside the roll-out and scaling-up of innovative practices.
- The MHTF advocacy at global and regional levels fortifies efforts, while drawing on national experiences and results.
- The MHTF provides catalytic financing with a strong emphasis on leveraging all potential resources, domestic and international, in support of maternal and newborn health.
- The MHTF is well placed to make powerful contributions to the SDGs, particularly SDG 3 and SDG 5. Results highlighted in this annual report clearly demonstrate the fund's distinctiveness and effectiveness within the United Nations and more broadly. Its capacity for catalytic funding is underpinned by strong technical expertise, and an integrated programmatic approach that unlocks rapid and sustainable change.

2015 has been an important year of global transition. The Sustainable Development Goals and the 2030 Agenda, agreed by all UN Member States, became a 15-year transformation plan for development, universal peace and protection of the planet. The plan is universal, and aims to reach and safeguard the human rights of all, especially those marginalized and discriminated against due to sex, age, race or economic condition. It seeks to advance gender equality in all aspects of life, from the household to political representation and the workplace.

The 2030 Agenda has been conceived for implementation across different sectors, in an integrated manner. Key to its realization will be the health goal and its targets to eliminate preventable maternal mortality, and achieve universal access to sexual and reproductive health and rights. In this context, a robust platform has been established during the second year of the MHTF business plan to bolster maternal health and sexual and reproductive health programmes in countries with a high burden of maternal mortality.

Priorities include:

A clear trajectory to support all efforts (global, regional and national), with a particularly strong focus at the country level, to implement SDG 3 and SDG 5, and as an essential part of this, the Global Strategy for Women's, Children's and Adolescents' Health.

Prioritization of interventions in the short to medium term that are context-specific, evidence-based and contribute in the longer term to the reduction of maternal mortality and morbidity, and improved health, including sexual and reproductive health.

Equity of purpose, with a strong focus on addressing marginalized populations such as first-time young mothers and fistula survivors, and those vulnerable due to geographical location and/or income level.

Strengthening of health systems to guarantee that maternal health and quality sexual and reproductive health care are accessible and acceptable to women and girls, and their rights to these are fully upheld.

The MHTF will support in particular:

Country leadership in the prioritization of maternal health and sexual and reproductive health and rights in national health sector strategies/investment cases with clear deliverables.

Comprehensive approaches encompassing financing, technical assistance, capacity-building and institutional strengthening.

Cost-effective, proven interventions that are part of a comprehensive approach where the catalytic funding of the MHTF contributes to the mobilization of domestic and external resources.

Supply- and demand-side synergies to ensure that the provision of quality health services, particularly to realize sexual and reproductive health and rights, matches the ability of targeted populations to exercise their rights to access such services.

Intersectoral collaboration and cooperation, given the critical links between maternal mortality and morbidity, and critical other sectors such as education, gender equality, etc.

The MHTF Midwifery Programme

In 2015, the MHTF continued to support the strengthening of midwifery education, regulation and associations in 39 countries, contributing to significant achievements:

- All MHTF-supported countries have initiated International Confederation of Midwives/WHO standards for midwifery pre-service training,
- More than half of MHTF-focused countries have developed a national costed midwifery workforce plan.
- Half of MHTF-supported countries have a governing body to regulate midwifery practice.
- Half of midwifery associations supported by MHTF have a costed plan.

However, further efforts are required to strengthen midwifery schools in MHTF-supported countries to follow International Confederation of Midwives/WHO standards.

Midwives should be effectively deployed and supported throughout their careers to provide quality care to women, adolescents and newborns. Their profession needs to be better valued and regulated in all MHTF-supported countries.

Scaling up pre-service training: The scale-up of competency and evidence-based pre-service training, in agreement with the International Confederation of Midwives' global standards, is critical to ensure equitable access to quality maternal and newborn health services, including emergency obstetric and newborn care. Practical training for midwifery students in accredited emergency obstetric and newborn care facilities should be a key component of pre-service training. Tutors for both pre- and in-service training should be continuously supported.

Data for training, planning and monitoring deployment of midwives: A way to foster a conducive environment for professional midwifery is to build the leadership capacities of national midwifery champions and advocate for enhanced national investments in quality midwifery care, using the latest data from the *State of the World's Midwifery Report 2014*, and the various midwifery workforce assessments. At the same time, to demonstrate the essential role of midwives, it will be critical to further collect regular data on them, including the deployment and recruitment of newly graduated midwives and the number of deliveries done by midwives in each country (for example, through survey tools such as the Demographic and Health Surveys).

Leadership, key to success. Finally, strong leadership, management and advocacy capacity in midwifery associations can drive national commitment to midwifery, and improve the distribution and retention of midwives, in particular in emergency obstetric and newborn care facilities. Associations well-equipped to influence policy can empower midwives themselves to better advocate for their profession.

Going Forward

UNFPA, through the midwifery programme, will continue to exercise its global leadership. It will work with all stakeholders and partners to ensure that midwifery continues to be recognized internationally, and mainstreamed in national human resources to implement health policies and plans.

In the context of the SDGs, UNFPA will seek a leading role in positioning midwifery within global initiatives such as the High-Level Commission on Health Employment and Economic Growth, led by the Presidents of France and South Africa. The Commission is set to find innovative ways to address health labour shortages, and ensure a good match between the skills of health workers and job requirements, a process that could draw on experiences and lessons accumulated by UNFPA through the MHTF.

Young midwifery leaders: UNFPA will help foster leadership capacities of young midwifery leaders in 2016 and organize a global Midwifery Symposium for Young Midwife Leaders at Women Deliver in Copenhagen. Young midwifery leaders will be able to champion the cause of midwifery and advocate for supportive regulations, career opportunities, continuous managerial and technical training and mentorship, adequate numbers of well-distributed posts for midwives, proper links between health facilities, and better working and living conditions

Innovation: E-learning initiatives will be scaled up and a mobile m-learning system introduced for improving the life-saving competencies of midwives in low-resource settings. UNFPA will also continue to support the Helping Mothers Survive/Helping Babies Breathe campaigns to fight post-partum haemorrhage, the leading cause of maternal mortality, and improve newborn resuscitation.

Emergency Obstetric and Newborn Care

The reduction of preventable maternal and newborn mortality and morbidity depends on the timely access of pregnant women and girls to quality emergency obstetric and newborn care services. The availability and quality of services are still limited in many MHTF-supported countries; only one country is reaching the international standard of five facilities per 500,000 people.

The ambitious SDG targets on maternal mortality, newborn deaths, and universal access to sexual and reproductive health care call for increasing focus on and investment in emergency obstetric and newborn care. As highlighted by the Independent Every Woman, Every Child Expert Review Group in their final report, "(T)he global community has largely failed to make progress in mobilizing action for (emergency obstetric and newborn care), however there is an opportunity to change the trajectory."

In collaboration with Averting Maternal Death and Disability, the MHTF has identified a three-pronged approach to supporting countries in progressively building their network of facilities providing quality emergency obstetric and newborn care services. This approach aims to strengthen planning processes for facility development, the availability and readiness of services, and their functioning and quality.

When planning an emergency obstetric and newborn care network, health ministries face challenging decisions related to **prioritizing which facilities provide emergency obstetric and newborn care**, and developing a costed plan to progressively reach the minimum international standard for the number of functioning facilities. A review of emergency obstetric and newborn care needs assessments from several countries showed that the planned numbers of facilities are often far above the international standard, which makes it very challenging for countries to effectively allocate scarce human resources and supplies, and sustainably ensure that quality services are available in all of these.

The **availability and readiness of emergency obstetric and newborn care services** requires additional efforts in strengthening the clinical competencies and confidence of newly trained midwives, strategically deploying them in the emergency obstetric and newborn care facility network, and ensuring the provision of continuous support to maintain their skills and readiness to provide services.

Finally, facility staff and district teams should be empowered to analyse their data, and take appropriate decisions and actions to improve the functioning and quality of emergency obstetric and newborn care services.

Data for monitoring emergency and newborn care facilities: The implementation of maternal and newborn health monitoring in emergency obstetric and newborn care facilities in some MHTF-supported countries confirms the importance of regular data collection and analysis for improving service readiness and functioning. The regular measurement of gaps in functions, staff (especially midwives), commodities and key programme elements allows health ministries to continuously adjust the maternal health programme to improve its responsiveness and effectiveness. Information about staff gaps in facilities is key to advocating for the deployment of skilled staff, in particular, midwives.

Going Forward

The MHTF will further implement its three-pronged approach to supporting countries in improving the availability and quality of emergency obstetric and newborn care services.

Data for prioritization: As the emergency obstetric and newborn care prioritization process and the development of a costed plan requires national data on services, the MHTF will assist countries that do not have recent data to perform a needs assessment. In 2016, it will support the finalization of the needs assessment in Zambia, and help countries that have recently conducted assessments to develop costed plans for services.

Monitoring maternal and newborn health in emergency obstetric and newborn care facilities: Based on the experiences of Haiti, Madagascar and Togo, the prioritization process for strategically identifying emergency obstetric and newborn care facilities will be documented for other MHTF-supported countries. Maternal and newborn health monitoring in these facilities will be further strengthened in Madagascar and Togo, especially through the regular analysis of data, and the development and implementation of responses to identified gaps. Additional countries will also be supported with monitoring, and the prioritization process and data analysis will be bolstered through the use of geographic information systems.

Link training centers for midwives with emergency obstetric and newborn facilities: The MHTF will back the development of accredited training centres for midwives in functioning basic emergency obstetric and newborn care facilities, with a special focus on quality of care.

Implementation science: Finally, countries will be aided in using “implementation science” to sustainably roll out evidence-based interventions that improve the availability and quality of emergency obstetric and newborn care services. There will be an emphasis on locally driven responses to gaps in readiness and quality of services, such as at the facility and district levels, and on continuously encouraging staff with coaching and mentorship by dedicated support teams.

Leveraging competency, organizational and leadership drivers to foster local solutions and staff empowerment should contribute to emergency obstetric and newborn care networks that provide high-quality maternal and neonatal health care in

a sustainable manner, and help reduce maternal and newborn mortality and morbidity, including obstetric fistula.

Maternal Death Surveillance and Response

The MHTF supports countries in setting up maternal death surveillance and response systems with a continuous cycle of identification, notification and review of maternal deaths, followed by actions to address gaps in the availability and quality of maternal health services:

- A maternal death surveillance and response policy framework is complete in most MHTF-supported countries, but plans are often elaborated without cost estimates or budgets.
- 22 MHTF-supported countries are monitoring the performance of their system.

Maternal death surveillance and response monitoring helps analyse implementation barriers (including fears of liability and punitive measures among health professionals), and can drive actions for increasing the numbers of maternal deaths that are registered and reviewed, which are still low in most MHTF-supported countries.

- Since 2015, available maternal death surveillance and response data from all UN Member States are being consolidated by WHO and UNFPA to better target needed support and follow progress over time.

Going Forward

Maternal death surveillance and response frameworks:

The MHTF will further support countries to set up and implement maternal death surveillance and response frameworks, costed implementation plans, annual reports and monitoring. It will particularly advocate for using the death notification rate to strengthen implementation of these systems, and contribute to annual reports that measure progress and inform decisions for further development.

Expand number of maternal death reviews: As in the emergency obstetric and newborn care component, the MHTF will support countries to increase the number of reviews at local levels and facilitate locally driven responses to address gaps. The MHTF will also assist midwives to advocate for verbal autopsies in communities, and aid families and local authorities in developing this procedure.

Maternal death surveillance and response systems: The MHTF will further build strategic alliances with partners to provide technical support and capacity strengthening to maternal death surveillance and response systems. The focus on civil registration and vital statistics in the 2030 Agenda for Sustainable Development is an opportunity to forge new partnerships and mobilize more resources to help countries develop and implement the systems.

The Campaign to End Fistula

Given that fistula is an entirely preventable and highly treatable condition, there is great possibility in the new global commitment of the 2030 Agenda to “leave no one behind”: fistula could be eliminated from the world. With sufficient political, human, institutional and financial resources, and concerted, accelerated, strategic action, an end to fistula can truly be envisioned.

- With MHTF support, an increasing number of women suffering from obstetric fistula have received treatment. This represents half of the total number of women that have undergone surgery repair.
- UNFPA and the Campaign to End Fistula continues to collaborate closely with the WHO, UN Member States and other key stakeholders to make obstetric fistula a nationally notifiable condition.

Going Forward

Data to identify obstetric fistula cases: In keeping with the MHTF’s strategy and core operating principle of supporting evidence-based, needs-driven programming, UNFPA and the Campaign to End Fistula are collaborating with the Johns Hopkins University School of Public Health to generate new UN estimates on fistula. This long-needed, high-quality data will enable governments, civil society organizations, health-care institutions and providers, and all other partners to finally have a clear picture of the magnitude of the problem, nationally and globally. This can in turn inform evidence-based policy and programming that reaches all women and girls at risk of fistula or in need of fistula care.

Advocacy to scale up obstetric fistula repair programmes:

UNFPA and the Campaign’s unique coordinating and convening roles afford the opportunity to conduct high-level advocacy and policy initiatives, including in the UN General Assembly, based on the UN Secretary-General’s report on

ending fistula, which delineates key recommendations. As a leader of the global Campaign to End Fistula, and convener of this coalition of nearly 100 global partners (plus hundreds more at regional, national and community levels), UNFPA galvanizes all partners working to end fistula around a common action plan for ending fistula. It will be based on what is known to work, and on the strengths and “niche” of each individual partner/stakeholder.

In May 2016, the United Nations Secretary-General announced a ground-breaking new vision for the International Day to End Obstetric Fistula: “End fistula within a generation.” The Secretary-General and UNFPA’s Executive Director called upon the global community to significantly raise the bar and commit to achieving the SDG vision of “leaving no one behind,” including the poorest and most vulnerable women and girls living with fistula. This represents a truly transformational opportunity for mobilizing all key stakeholders to erase a horrific and preventable health and human rights tragedy.

As highlighted in the *Lancet Global Health* commentary²¹ on obstetric fistula and stillbirths: “As the global community mobilises around the Sustainable Development Goals and recently launched Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–30), ending preventable maternal and newborn deaths has moved from a seemingly distant dream to a concrete, actionable goal. When speaking of ending preventable deaths, including stillbirths, one should remember the human rights imperative of ending the egregious suffering of those women and girls with fistula.”

First-Time Young Mothers

The MHTF will continue to advocate at the national level for making first-time young mothers a priority, including by paying special attention to them in reproductive, maternal, newborn, child and adolescent health strategies and plans. Globally, there is increased interest in adolescents, including those who have become mothers. The UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health has included adolescents for the first time, and there is a widespread interest in preventing pregnancy among adolescents and supporting first-time mothers.

In 2015, more time was spent in providing strategic direction and technical support to countries working under this component of MHTF assistance:

- In Liberia, some health-care workers needed further training on how to provide friendly and respectful care for first-time young mothers. Activities have also started in several countries, including Madagascar and Benin. A concept note about the MHTF output has been developed in order to prepare for nationally scaling up interventions.
- Challenges in the recruitment of first-time pregnant mothers have been noticed, and methods to overcome these are being discussed. One lesson is that the community health worker plays a very important role in supporting first-time young mothers to access health services, and can be a trusted link between pregnant girls and health-care facilities.
- Sometimes home visit follow-up has been a challenge because there is a lack of information about where the girl lives. This underlines the need to develop innovative approaches for tracking girls and disseminating information. In some countries, for example, Uganda, a pilot mobile phone app for maternity care is under development.

Going Forward

Guidance to countries and monitoring tools.

The MHTF is very well positioned to back new initiatives, including through a learning platform set up to help countries move forward as well as the development of tools that are based on lessons learned from country implementation. It will support countries interested in rolling out interventions for first-time young mothers, and strengthen the skills of health facility providers, such as nurses and midwives, in giving respectful quality of care and counselling to pregnant adolescent girls. In 2016, an additional nine UNFPA country offices will put together plans for initiatives for first-time young mothers.

²¹ Source: www.thelancet.com/lancetgh, vol. 4, February 2016.

The Midwifery Programme

Emergency Obstetric and Newborn Care

The Campaign to End Fistula

Maternal Death Surveillance and Response

First-Time Young Mothers

...IN CONCLUSION,

As the MHTF looks to 2016 and beyond, it will continue to implement the second phase of its business plan in-line with UNFPA's Strategic Plan. It will target these five integrated interventions, continue to expand them, and build on results achieved and lessons learned.

The MHTF is strongly positioned to support the realization of the 2030 Agenda and the Global Strategy for Women, Children and Adolescents' Health.

In all its efforts, UNFPA's MHTF will work to reduce maternal and newborn mortality, and maternal morbidity, and to protect and fulfil the rights of all women and girls to sexual and reproductive health.

ANNEX 1: CAMPAIGN TO END FISTULA PARTNERS

1. Aden Hospital (Yemen)
2. African Medical and Research Foundation
3. American College of Nurse-Midwives
4. Babbar Ruga Fistula Hospital (Nigeria)
5. Bangladesh Medical Association
6. Bill & Melinda Gates Institute for Population and Reproductive Health
7. Bugando Medical Center (Tanzania)
8. CARE
9. Centers for Disease Control and Prevention
10. Centre Mère-Enfant (Chad)
11. Centre National de Référence en Fistule Obstétricale (Niger)
12. Centre National de Santé de la Reproduction & du Traitement des Fistules (Chad)
13. Columbia University's Averting Maternal Death and Disability Program
14. Comprehensive Community Based Rehabilitation in Tanzania
15. CURE International Hospital of Kabul (Afghanistan)
16. Direct Relief International
17. Dr. Abbo's National Fistula and Urogynaecology Center (Sudan)
18. East Central and Southern Africa Association of Obstetrical and Gynecological Societies
19. EngenderHealth
20. Equilibres & Populations
21. Eritrea Women's Project
22. Family Care International
23. Fistula e.V.
24. Fistula Foundation
25. Fistula Foundation Nigeria
26. Freedom from Fistula Foundation
27. Friends of UNFPA
28. Geneva Foundation for Medical Education and Research
29. Girls' Globe
30. Governess Films
31. Gynocare Fistula Center (Kenya)
32. Hamlin Fistula (Ethiopia)
33. Healing Hands of Joy (Ethiopia)
34. Health and Development International
35. Health Poverty Action (Sierra Leone)
36. Hope Again Fistula Support Organization (Uganda)
37. Human Rights Watch
38. Institut de Formation et de Recherche en Urologie et Santé de la Famille (Senegal)
39. International Confederation of Midwives
40. International Continence Society
41. International Federation of Gynecology and Obstetrics
42. International Forum of Research Donors
43. International Nepal Fellowship
44. International Planned Parenthood Federation
45. International Society of Obstetric Fistula Surgeons
46. International Urogynecological Association

ANNEX 1: Campaign to End Fistula Partners (continued)

47. International Women's Health Coalition
48. Islamic Development Bank
49. Johnson & Johnson
50. Johns Hopkins Bloomberg School of Public Health
51. Kupona Foundation
52. Lake Tanganyika Floating Health Clinic
53. Ligue d'Initiative et de Recherche Active Pour la Santé et l'Education de la Femme (Cameroon)
54. London School of Hygiene and Tropical Medicine
55. Maputo Central Hospital (Mozambique)
56. Médecins du Monde
57. Médecins Sans Frontières
58. Mercy Ships
59. Moi University (Kenya)
60. Monze Hospital (Zambia)
61. Mulago Hospital/Medical School (Uganda)
62. National Obstetric Fistula Centre, Abakiliki (Nigeria)
63. Obstetrical and Gynecological Society of Bangladesh
64. One by One
65. Operation Fistula
66. Pakistan National Forum on Women's Health
67. Pan African Urological Surgeons' Association
68. Population Media Center
69. Psychology Beyond Borders
70. Regional Prevention of Maternal Mortality Network (Ghana)
71. Royal College of Obstetricians and Gynaecologists
72. Sana'a Hospital (Yemen)
73. Selian Fistula Project (Tanzania)
74. Société Africaine des Gynécologues-Obstétriciens (SAGO)
75. Société Internationale d'Urologie
76. Solidarité Femmes Africaines
77. The Association for the Rehabilitation and Re-orientation of Women for Development (Uganda)
78. Uganda Childbirth Injury Fund
79. United Nations Population Fund
80. United States Agency for International Development
81. University of Aberdeen
82. University Teaching Hospital of Yaoundé (Cameroon)
83. Virgin Unite
84. White Ribbon Alliance
85. Women and Health Alliance International
86. Women's Health Organization International
87. Women's Hope International
88. Women's Missionary Society of the African Methodist Episcopal Church
89. World Health Organization
90. World Vision
91. Worldwide Fistula Fund
92. Zonta International

ANNEX 2: MATERNAL DEATH AVERTED²²

For each country, maternal mortality ratio estimates for the years 1990, 1995, 2000, 2005, 2013 and 2015 were taken from *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. Estimates for intervening years were interpolated assuming a linear trend.

For each country, estimates of the number of live births in each year from 1990 to 2015 were taken from the United Nations Population Division's World Population Prospects website, using the medium variant estimates.

For each country, the number of maternal deaths in each year from 1990 to 2015 was calculated as follows:

- $MMR_y * B_y / 100,000$
- Where MMR = maternal mortality ratio, y = year and B = number of births.

For each country, the number of maternal deaths that would have occurred in each year from 1990 to 2015 had the country's maternal mortality ratio remained at its 2010 level was calculated for each year from 2011 to 2015 as follows:

- $MMR_{2010} * B_y / 100,000$
- Where MMR = maternal mortality ratio, y = year and B = number of births.

For each country, the number of lives saved in each year was calculated by subtracting the actual number of maternal deaths for that year from the counterfactual number of maternal deaths for that year. The numbers for 2011 to 2015 inclusive were summed to give an estimate of the total number of deaths averted since 2010.

²² Updated from Every Woman, Every Child, Saving lives, protecting futures, progress report on the global strategy for women's and children's health 2010-2015, p. 109.

ANNEX 3: RESOURCES

INDICATORS FRAMEWORK

Outcome A : Strengthened national capacity to implement comprehensive midwifery programs													
Indicators	Proportion of births attended by skilled health personnel for the poorest quintile of the population		A national costed midwifery workforce plan is incorporated in the national HRH plan		Curriculum for midwifery pre-service training is based on ICM/WHO standards		Number of midwifery school supported by the MHTF		A governing body regulates midwifery practice		The national midwifery association has a "budgeted Strategic Action Plan"		
	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015	
Afghanistan	-	-	N	N	Y	Y	0	2	N	N	Y	Y	
Bangladesh	31.7%	45.0%	N	Y	Y	Y	16	31	N	Y	N	Y	
Benin	84%	100%	Y	Y	Y	Y	1	1	Y	Y	N	Y	
Burkina Faso	50.5%	67.5%	Y	Y	Y	Y	8	8	Y	Y	Y	Y	
Burundi	73%	-	N	Y	Y	Y	1	1	N	Y	N	N	
Cameroon	19.1%	-	-	-	Y	Y	0	10	N	N	Y	Y	
Central African Republic	33.1%	-	Y	Y	Y	Y	0	0	Y	Y	N	Y	
Chad	-	-	Y	Y	Y	Y	1	3	N	Y	N	Y	
Congo	-	-	N	N	Y	Y	2	2	Y	Y	N	N	
Côte d'Ivoire	35%	-	Y	Y	Y	Y	5	5	Y	Y	Y	Y	
Democratic Republic of the Congo	-	-	N	N	Y	Y	6	-	N	N	Y	Y	
Ethiopia	16%	-	N	N	Y	Y	31	-	N	Y	Y	Y	
Ghana	38.6%	46.9%	N	N	Y	Y	20	25	Y	Y	Y	Y	
Guinea	45%	45%	Y	Y	Y	Y	-	0	Y	Y	Y	Y	
Guinea Bissau	-	-	Y	Y	Y	Y	-	0	-	N	-	Y	
Haiti	9.6%	15%	N	Y	Y	Y	1	1	N	N	N	Y	
Kenya	44%	62%	-	N	Y	Y	0	1	Y	Y	N	Y	
Lao People's Democratic Republic	-	-	Y	Y	N	Y	9	9	Y	Y	N	Y	
Liberia	61%	43.2%	N	Y	Y	Y	4	5	Y	Y	Y	Y	
Madagascar	27%	-	N	N	N	Y	6	6	Y	Y	N	N	
Malawi	71%	71%	Y	Y	Y	Y	1	1	Y	Y	Y	Y	
Mali	-	-	Y	Y	Y	Y	5	5	Y	Y	Y	Y	
Mauritania	-	-	-	Y	N	Y	2	5	N	Y	N	N	
Mozambique	-	-	Y	Y	Y	Y	0	0	N	N	N	N	
Nepal	-	-	N	N	N	N	0	0	N	Y	Y	Y	
Niger	-	-	Y	Y	N	Y	2	2	N	N	N	Y	
Nigeria	6%	-	N	N	N	N	0	24	Y	Y	N	-	
Pakistan	-	-	Y	Y	N	N	16	1	Y	Y	-	N	
Rwanda	-	-	N	N	N	N	0	8	Y	Y	N	Y	
Senegal	-	-	N	N	Y	Y	0	1	N	Y	N	N	
Sierra Leone	-	-	N	N	N	N	0	2	Y	Y	N	N	
Somalia	-	-	Y	Y	Y	Y	6	11	Y	Y	N	Y	
South Sudan	-	-	N	N	Y	Y	1	1	N	N	N	N	
Sudan	-	-	N	N	N	N	-	23	N	N	-	N	
Timor-Leste	-	-	N	N	Y	Y	1	1	N	N	N	N	
Togo	-	-	N	Y	Y	Y	2	2	N	N	N	Y	
Uganda	-	-	Y	Y	N	Y	18	18	Y	Y	N	N	
Yemen	17%	-	N	-	Y	-	0	-	N	-	N	-	
Zambia	-	-	Y	Y	N	Y	3	4	Y	Y	N	Y	

Annex 3: Resources Indicators Framework (continued)

Outcome B: Strengthened national capacity for quality integrated maternal health services, including emergency obstetric and newborn care (EmONC)																
Indicators	Proportion of women with major direct obstetric complications treated in EmONC facilities		The health national costed plan includes EmONC facilities development with annual targets		EmONC services are monitored in prioritized EmONC facilities		Each midwifery national school has at least one Basic EmONC and one Comprehensive EmONC facilities accredited as midwifery training centers		Direct obstetric complications are documented in each EmONC facility		Case Fatality Rate (CFR) per direct obstetric complication are systematically documented at C EmONC level		A costed plan exists for Reproductive Health integrated services in EmONC facilities		Proportion of women leaving EmONC facilities with a contraceptive modern method	
	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015
Afghanistan	-	-	Y	Y	Y	Y	Y	N	Y	Y	N	N	Y	Y	-	-
Bangladesh	-	-	N	Y	Y	Y	N	N	Y	Y	-	Y	N	N	-	N
Benin	23%	-	Y	Y	Y	Y	Y	Y	Y	Y	-	N	-	Y	Y	-
Burkina Faso	18%	25%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	-	26%
Burundi	51%	-	Y	Y	Y	Y	Y	N	Y	Y	Y	INF 0,4%	N	Y	ND	20%
Cameroon	-	-	Y	-	N	N	N	N	N	N	N	N	N	-	N	-
Central African Republic	29%	-	N	N	N	N	Y	Y	N	Y	N	Y	N	Y	-	-
Chad	-	-	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	ND	Y
Congo	-	-	Y	Y	N	Y	N	N	N	Y	N	Y	N	Y	ND	ND
Côte d'Ivoire	39%	-	N	N	Y	Y	N	Y	N	N	N	N	N	N	ND	ND
Democratic Republic of the Congo	-	-	Y	-	Y	-	N	-	Y	-	Y	-	N	-	-	-
Ethiopia	-	-	-	-	-	-	Y	-	-	-	-	Y	Y	-	-	-
Ghana	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	-
Guinea	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	0,68	-
Guinea Bissau	-	-	Y	Y	Y	Y	Y	Y	Y	-	Y	-	Y	-	Y	-
Haiti	20%	16%	N	Y	Y	Y	Y	Y	N	N	N	N	N	Y	N	-
Kenya	3.70%	3.95%	Y	-	Y	-	Y	Y	Y	Y	Y	-	N	Y	-	-
Lao People's Democratic Republic	-	-	N	Y	Y	Y	N	N	N	N	N	Y	N	Y	-	-
Liberia	-	-	Y	Y	Y	N	Y	Y	Y	N	Y	Y	Y	Y	N	29%
Madagascar	N/A	N/A	Y	Y	N	Y	Y	Y	N	N	N	N	Y	Y	N/A	N/A
Malawi	-	-	Y	Y	Y	-	-	N	Y	Y	Y	Y	Y	Y	-	-
Mali	-	-	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	-	-
Mauritania	-	-	N	N	N	N	N	N	N	N	N	N	Y	N	N	N/A
Mozambique	-	-	Y	N/A	Y	Y	N	Y	Y	Y	2,4	N/A	Y	Y	N/A	N/A
Nepal	-	-	N	N/A	Y	Y	N/A	N/A	Y	Y	Y	inf 1	N	N/A	-	-
Niger	-	-	Y	Y	Y	Y	N	Y	Y	31%	Y	2,30%	Y	Y	-	ND
Nigeria	-	-	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	-	-
Pakistan	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rwanda	-	-	N	Y	N	Y	-	ND	-	ND	-	N	-	ND	-	ND
Senegal	-	-	N	N	Y	N	N	Y	Y	Y	Y	Y	Y	N	-	ND
Sierra Leone	-	-	Y	Y	Y	Y	Y	Y	Y	Y	-	Y	Y	Y	-	ND
Somalia	-	-	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	0,39	N/A
South Sudan	-	-	N	Y	N	N	N	N	N	N	N	N	N	N	NA	N/A
Sudan	-	-	-	Y	-	Y	-	N	-	Y	-	Y	-	in some states	-	N
Timor-Leste	-	-	N	N	N	N	N	N	N	N	-	N	Y	Y	N	N
Togo	-	23,70%	Y	Y	Y	Y	N	N	Y	Y	Y	Y	N	Y	-	5%
Uganda	-	-	N	Y	N	N	Y	Y	Y	N	N	N	-	Y	-	inf 10%
Yemen	40%	-	Y	-	N	-	Y	-	Y	-	N	-	Y	-	-	-
Zambia	-	-	N	N	Y	N	Y	ND	N	N	N	ND	Y	Y	N	ND

Annex 3: Resources Indicators Framework (continued)

Outcome C : Enhancing national capacity for prevention, treatment and social reintegration for obstetric fistula										
Indicators	A costed human resources for health strategy is in place which includes fistula surgeons		Number of skilled, expert fistula surgeons meets projected needs for number of fistula repairs in the country		A costed national plan/strategy for ending fistula is developed and being implemented as part of an overall health strategy		A functioning National Task Force for Fistula is in place		A national register is in place to record notifications and track fistula cases at community and facility level	
	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015
Afghanistan	N	Y	N	N	N	N	N	Y	N	Y
Bangladesh	N	N	-	24	N	Y	N	Y	N	Y
Benin	Y	Y	N	N	Y	Y	N	N	N	Y
Burkina Faso	Y	Y	Y	-	Y	Y	Y	Y	Y	Y
Burundi	N	N	N	Y	N	N	Y	Y	N	N
Cameroon	N	N/A	N	N	N	N	Y	Y	N	-
Central African Republic	Y	Y	Y	Y	N	N	Y	Y	N	N
Chad	N	N	-	8/450	Y	N	Y	Y	N	Y
Congo	N	N	N	N	N	Y	Y	Y	Y	Y
Côte d'Ivoire	Y	Y	Y	Y	Y	N	N	Y	N	N
Democratic Republic of the Congo	N	-	-	-	N	N	Y	Y	N	-
Ethiopia	Y	-	-	-	Y	Y	Y	Y	N	-
Ghana	N	N	N	N	N	N	N	Y	Y	N
Guinea	Y	Y	-	20	Y	Y	Y	Y	N	N
Guinea Bissau	-	Y	-	N	Y	N	Y	Y	Y	N
Haiti	-	-	-	-	-	N	-	N	-	-
Kenya	N	N	-	N	N	N	Y	Y	N	N
Lao People's Democratic Republic	-	-	-	-	-	N	-	-	-	-
Liberia	Y	Y	-	Y	Y	N	Y	Y	Y	Y
Madagascar	Y	N	N	3	N	Y	N	Y	N	N
Malawi	-	Y	-	N/A	N	N	Y	Y	N	N
Mali	Y	Y	-	20	Y	Y	Y	Y	-	-
Mauritania	N	N	-	6	N	N	N	N	N	N
Mozambique	N	N	N	N	Y	Y	Y	Y	N	N
Nepal	N	N/A	N	N/A	N	N	Y	Y	N	N
Niger	Y	Y	-	13	Y	Y	Y	Y	N	N
Nigeria	N	N	-	11	Y	Y	Y	Y	N	N
Pakistan	-	-	-	-	-	N	-	-	-	-
Rwanda	N	N	N	N	N	N	N	N	N	N
Senegal	Y	N	-	76/150	Y	Y	Y	Y	Y	Y
Sierra Leone	N	N	N	N	Y	Y	N	NA	Y	Y
Somalia	N	N	N	N	N	N	N	Y	N	N
South Sudan	N	N/A	N	0.80%	N	N	N	N	N	N
Sudan	-	N	-	N/A	-	N	-	N	-	N
Timor-Leste	-	-	-	-	-	N	-	-	-	-
Togo	N	Y	N	Y	Y	Y	Y	Y	N	N
Uganda	Y	Y	N	N	Y	Y	Y	Y	N	N
Yemen	N	-	-	-	N	N	N	N	N	-
Zambia	N	ND	N	4	N	N	N	Y	N	Y

Annex 3: Resources Indicators Framework (continued)

Outcome D : Enhanced national capacity for maternal death surveillance and response.								
Indicators	Proportion of countries where maternal deaths that are notified at a) facility level; b) at community level reach 80 % of expected deaths notified as defined every year for a) and b)		An inter-ministerial MDSR committee is functioning		The MDSR development system is monitored		All subnational subdivisions are producing an annual MDSR report	
	2014	2015	2014	2015	2014	2015	2014	2015
Afghanistan	-	-	N	Y	N	Y	N	Y
Bangladesh	-	-	N	N	N	Y	N	Y
Benin	1,200	-	N	-	N	Y	N	Y
Burkina Faso	20%	23%	Y	Y	Y	Y	Y	Y
Burundi	Y	Y facilities	N	Y	Y	Y	N	Y
Cameroon	-	-	-	-	-	N	-	N
Central African Republic	-	-	Y	Y	Y	Y	N	Y
Chad	-	-	N	N	Y	Y	N	Y
Congo	-	-	N	N	Y	Y	-	Y
Côte d'Ivoire	N	N	N	Y	Y	Y	N	Y
Democratic Republic of the Congo	-	-	N	N	Y	-	N	-
Ethiopia	-	-	-	N	-	Y	N	Y
Ghana	-	80.70%	N	N	N	N	N	N
Guinea	-	-	Y	Y	Y	Y	Y	Y
Guinea Bissau	-	-	Y	Y	-	Y	-	Y
Haiti	18%	-	N	N	N	Y	N	Y
Kenya	-	-	N	N	Y	Y	N	Y
Lao People's Democratic Republic	-	-	Y	Y	Y	Y	9/18	Y
Liberia	Y	-	N	Y	Y	N	N	N
Madagascar	-	N	N	Y	Y	N	N	N
Malawi	-	-	Y	Y	Y	Y	N	Y
Mali	-	-	N	N	N	Y	Y	Y
Mauritania	-	-	N	N	N	N	N	N
Mozambique	-	-	Y	Y	N	Y	N	Y
Nepal	-	-	N	N	-	N	-	N
Niger	-	-	Y	Y	Y	Y	N	Y
Nigeria	-	-	N	N	N	N	N	N
Pakistan	-	-	-	-	-	-	-	-
Rwanda	-	-	N	Y	Y	Y	N	Y
Senegal	-	-	Y	N	Y	Y	N	Y
Sierra Leone	-	-	-	Y	-	Y	-	Y
Somalia	-	-	N	N	N	N	N	N
South Sudan	-	-	N	N	N	N	N	N
Sudan	-	Y	-	Y	-	Y	-	Y
Timor-Leste	-	-	N	N	N	Y	N	Y
Togo	-	-	Y	N	Y	Y	N	Y
Uganda	-	-	N	N	Y	Y	N	Y
Yemen	N	-	Y	-	N	-	N	-
Zambia	-	N	N	N	N	?	N	?

Annex 3: Resources Indicators Framework (continued)

Outcome E : Strengthened national capacity to reach and serve first-time young mothers									
Indicators	Age-disaggregated ANC utilization: Percentage of girls and women aged 15-19 and 20-24 who had a live birth that received antenatal care provided by a doctor, nurse, or midwife at least once during pregnancy, and at least four times during pregnancy		Age-disaggregated Skilled Birth Attendance: Percentage of births to girls and women 15-19 and 20-24 attended by skilled health personnel (doctors, nurses or midwives)		14.1. First-time young mothers are a priority population in the national RMNCAH plan		15.1. At least one innovative, scalable approach to improving maternal health service utilization by first-time young mothers is implemented		
	2014	2015	2014	2015	2014	2015	2014	2015	
Afghanistan	-	-	-	-	N	Y	N		Y
Bangladesh	-	-	-	-	N	N	N		N
Benin	86%	-	84%	-	Y	Y	Y		Y
Burkina Faso	< 20 y.o: 96,3%	< 20 y.o: 93%	< 20 y.o: 68,5%	< 20 y.o: 82%	Y	Y	-		Y
Burundi	100%	-	73%	-	N	N	N		N
Cameroon	N	-	N	-	N	N	N		N
Central African Republic	< 20 y.o: 69%	< 20 y.o: 67%	-	-	N	Y	Y		Y
Chad	-	-	-	-	N	Y	N		Y
Congo	-	-	-	-	Y	Y	N		N
Côte d'Ivoire	ND	-	58%	-	N	N	N		N
Democratic Republic of the Congo	-	-	-	-	N	-	N		-
Ethiopia	20%	-	19%	-	-	N	-		N
Ghana	-	-	-	-	Y	Y	Y		Y
Guinea	-	-	-	-	ND	-	N		N
Guinea Bissau	-	-	-	-	-	N	-		-
Haiti	N	-	N	-	N	Y	N		N
Kenya	88.5% 93%	-	46.6% 42.7%	-	N	Y	N		Y
Lao People's Democratic Republic	-	-	-	-	N	-	N		-
Liberia	97%	-	-	-	N	N	N		Y
Madagascar	-	80,9%	-	42,4%	N	Y	N		Y
Malawi	-	-	-	-	-	Y	-		-
Mali	-	-	-	-	N	N	-		N
Mauritania	-	-	-	-	N	N	N		N
Mozambique	-	-	-	-	N	-	N		-
Nepal	-	-	-	-	-	N	-		N
Niger	-	-	-	-	Y	Y	N		Y
Nigeria	-	-	-	-	N	N	N		N
Pakistan	-	-	-	-	-	-	-		-
Rwanda	-	-	-	-	-	N	-		-
Senegal	-	-	-	-	Y	Y	N		N
Sierra Leone	-	-	-	-	-	Y	-		Y
Somalia	-	-	-	-	N	N	N		N
South Sudan	-	-	-	-	N	N	N		N
Sudan	-	-	-	-	-	N	-		N
Timor-Leste	-	-	-	-	-	-	-		-
Togo	-	-	-	-	Y	Y	N		Y
Uganda	-	-	-	-	N	Y	N		N
Yemen	-	-	-	-	Y	Y	Y		Y
Zambia	-	-	-	-	Y	Y	Y		Y

The Maternal Health Thematic Fund

Towards the 2030 Agenda: Leaving no one behind in the drive for maternal health

Shifting from the Millennium Development Goals to the ambitious 2030 Agenda for Sustainable Development, the Maternal Health Thematic Fund has supported 39 countries in addressing the unfinished agenda of the MDGs and building foundations to achieve the Sustainable Development Goals. It focuses on high-impact interventions to improve the health and well-being of every woman, every girl and every newborn.

For the five focus areas of the MHTF, such high-impact interventions include:

Midwifery:

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

Emergency obstetric and newborn care:

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

Maternal death surveillance and response:

- Establishment of national scale systems
- Measures ensuring quality data
- Efficient response to identify causes of maternal mortality

The Campaign to End Fistula:

- Training of expert obstetric fistula surgeons
- Integration of obstetric fistula surgery into health systems for continuous care
- Identification of fistula cases for treatment, rehabilitation and social reintegration

First-time young mothers:

- Outreach to young pregnant girls to ensure skilled assistance during pregnancy and childbirth
- Post-partum follow-up and longer term support groups
- Further identification of innovative and scalable approaches to reach first-time young mothers



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